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Select Committee on Drugs

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TORONTO ONTARIO

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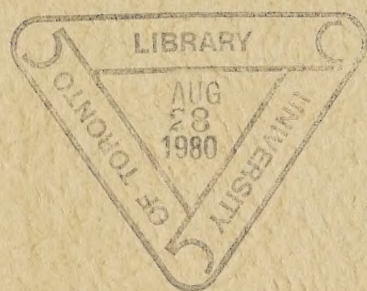
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SELECT COMMITTEE ON DRUGS

Proceedings of hearings
held at Parliament Buildings,
Toronto, Ontario, on Tuesday,
the 14th day of June, 1960,
at 10.00 a.m.

PRESENT:

MR. H. L. ROWNTREE, Q.C., Chairman

MR. A. WREN

MR. J. A. FULLERTON

MR. J. TROTTER

MR. R. E. SUTTON

MR. R. J. BOYER

MR. N. WHITNEY

MR. H. J. PRICE

MR. K. BRYDEN



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1 APPEARANCES:

2	FREDERICK E STAPLES	Ontario Department of Health
3	C. M. LIVINGSTONE	Ontario Department of Health
4	S. A. HOLLING, M.D.	Ontario Department of Health
5	DOUGLAS WISE	Ontario Department of Health, Division of Tuberculosis Prevention.
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7	W. J. GELDART	Cyanamid
8	DR. W. G. BROWN	Deputy Minister, Ontario Department of Health
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10	DONALD R. GUNN, M.D.	Mental Health Division, Ontario Hospital, New Toronto
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18	S. W. MARTIN	Ontario Hospital Association
19	JOSEPH HUTCHINSON	Glaxo-Allenbury's (Canada) Limited.
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21	J. F. HENDERSON	Canadian Ph. Journal
22	F. N. HUGHES	Dean, Faculty of Pharmacy, University of Toronto
23	J. G. NAIRN	Assistant Professor, Faculty of Pharmacy, University of Toronto
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27	W. W. CUNNINGHAM	Department of Reform Institutions
28	DOUGLAS R. WESTON	Canadian Pharmaceutical Manufacturers Association.
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1 THE CHAIRMAN: This is the first meeting of
2 the Select Committee appointed at the last session of
3 the Legislature to inquire into matters pertaining to
4 the cost of drugs and it is directed particularly to
5 the sales and consumption of drugs in and by hospitals
6 in Ontario.

7 At this point I would like to introduce and
8 name the members of the Committee who are present.
9 They are on my right, Mr. John Fullerton, on my left
10 Mr. Albert Wren, Mr. Norris Whitney, Mr. Robert Boyer,
11 Mr. H. J. Price, Mr. Richard Sutton, Mr. Kenneth
12 Bryden and Mr. James Trotter. Messrs. John White of
13 London and Gordon Laverne are not with us at this
14 moment.

15 Now, I would also like to introduce the
16 Secretary of the Committee, Mr. S. J. Gadsby, who has
17 been appointed Secretary and who will be available for
18 such liaison as required by the public.

19 I will now read the Terms of Reference.

20 The Terms of Reference are contained in a motion
21 passed in the House on Wednesday, April 6th last, and
22 for the record I will read the motion.

23 ORDERED: That a Select Committee of this
24 House be appointed to inquire into, study and review the
25 entire matter of the cost of drugs and pharmaceutical
26 preparations of all kinds used in the treatment of
27 patients in public, general and mental hospitals and
28 sanatoria in Ontario and all matters relevant thereto,
29 including the present method and practices followed in
30

1 respect of purchase, distribution, analysis, storage,
2 inventory and accounting thereof in such institutions;
3 and in particular as to whether the costs are reason-
4 able, having regard to costs of production and costs
5 charged to the general public:

6 And that such Select Committee shall consist
7 of eleven members, and shall have authority to sit
8 during the interval between sessions, have full power
9 and authority to call any person, paper and things,
10 to examine witnesses under oath and the Assembly doth
11 command and compel attendance before such Select
12 Committee of such persons and production of such
13 papers and things as the Committee may deem necessary
14 in any of these proceedings and deliberations; for
15 which purpose the Honourable Speaker may issue his
16 warrant or warrants.

17 Now, before we proceed further, I see the
18 Minister of Health, Dr. Dymond, present in the room.

19 HON. MR. DYMOND: Yes, Mr. Chairman.

20 THE CHAIRMAN: Have you anything to say at
21 this point of the proceedings?

22 HON. MR. DYMOND: Mr. Chairman, Members of
23 the Committee, Ladies and Gentlemen. I want to take
24 this opportunity to bid you welcome, if such is in
25 order and on an occasion such as this. I must admit
26 to you that I am somewhat overawed by the solemnity
27 and concern that seems to pervade this room which has
28 at other times, while I have been present, seen
29 rather more boisterous gatherings, I must admit.
30



1
2 However, Mr. Chairman, I have no idea of
3 how boisterous your gathering may become as time goes
4 along.

5 However, the reason I am seeking the oppor-
6 tunity to come and speak to you is, as I said before,
7 to bid you welcome and to state to you that this is a
8 matter which has caused the Government and the members
9 of the Legislative Assembly a good deal of concern and
10 to which they have devoted a great deal of time and
11 study during the last session and in the case of many
12 members for months and even years prior to that time.
13 This is a matter which has brought about very wide-
14 spread concern to the public.

15 As a result, and as your Chairman has just
16 noted to you, it was deemed wise by the Government that
17 this Select Committee be set up to see if we could find
18 out whether some of the things that have been said for
19 and against this matter might not be brought more
20 clearly into perspective first of all from these deli-
21 berations and out of these deliberations the public
22 may get some idea where they stand in this matter of
23 the cost of drugs.

24 A great deal of concern has been experienced
25 by all of us about the increasing cost of health and
26 much of it is laid, from time to time, at the doorstep
27 of the drug companies and those responsible for placing
28 prices upon drugs -- the prices charged to the public
29 at large.

30 In the case of this Committee, its first



1 concern is the price charged or the cost of the drugs
2 for hospital care, which is taken up because of the
3 cost of drugs.

4 To that end, I have tried, Mr. Chairman, to
5 have my Department provide for you all the information
6 we have available which you may want. If we have
7 not provided all you may want then, if it is available,
8 sir, I can assure you all the members of my staff are
9 at your disposal to give you whatever information,
10 co-operation and help you may need in this matter.

11 We have taken the liberty of suggesting
12 among ourselves and on occasion, I believe, to you,
13 sir, we have others who might be helpful to you in the
14 deliberations of your Committee. If, in this way, we
15 can be of further assistance to you, again I am sug-
16 gesting you do not hesitate to call upon us.

17 I have nothing further to say at this time,
18 sir, except to say that every one of us, from myself
19 down throughout the members of my staff, will be
20 watching your deliberations with a great deal of interest
21 because we hope that out of these deliberations, as I
22 have already said, will come a much clearer picture of
23 this whole subject of drugs, their need, their relation-
24 ship to the care and treatment of the sick and their
25 cost -- the proportion that they bear to the cost of
26 the care and treatment of the sick.

27 I wish you well in your deliberations, sir,
28 which, as I say, we will watch with a great deal of
29 interest.
30



1
2 THE CHAIRMAN: Thank you very much, Dr.
3 Dymond.

4 Now, by virtue of the nature of this Committee,
5 it was not possible or desirable to call it together
6 for organization purposes and hence our short meeting
7 this morning. We have agreed to proceed as arranged
8 with certain evidence from the Ontario representative
9 of the Department of Health, including a statement
10 from the Dean of Pharmacy, F.N. Hughes. There will
11 be statements at this opening session which probably
12 will last through till Thursday of this week from the
13 Ontario Medical Association, the Ontario Hospital
14 Services Commission and the Ontario Hospital Association.

15 Now, the broad picture is this: that there
16 are government institutions which are operated by the
17 government. The Ontario Hospital Association has a
18 membership of some 230 members and there are some
19 small number of hospitals, six or eight I believe,
20 throughout Ontario which do not belong to this Associa-
21 tion. These 230 odd hospitals, outside government
22 jurisdiction, of course, fall into various classifica-
23 tions and their procedures, including those existing
24 and prevailing in government institutions, will be
25 considered in accordance with the Terms of Reference.

26 I have some observations I would like to
27 make with respect to the subject matter and the general
28 conduct of these proceedings. May I say to everyone
29 that you will be received courteously and your
30 evidence and statements will be welcomed by the



1 Committee. Please bear in mind that this Committee is
2 a committee of laymen and the subject matter involved,
3 particularly the highly-developed vocabulary, with
4 which we may or may not be acquainted, may prove
5 difficult for us and having that in mind, it occurred
6 to me and the Committee that those interested parties
7 in this hearing should come prepared with written
8 statements. I am not trying to make it difficult or
9 to add a burden. I would think that having in mind
10 the problems of vocabulary that may exist, that you
11 would be well advised if your material was prepared.
12

13 In that situation, we would hope that you
14 would provide the Secretary with some 25 copies and
15 we would also suggest to you that you have additional
16 copies available for exchange with other interested
17 parties to this subject.
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1 The arrangements have not been completed with
2 respect to the transcript of evidence, but permission
3 has been granted to Messrs. Angus, Stonehouse & Company
4 to take the transcript of evidence and those who are
5 interested in subscribing, shall we say, for a modest
6 fee are directed to Mr. Chapman of that firm or one of
7 his assistants. Now I might say that the suggestion
8 about this transcript is that the transcript coming three
9 weeks later is not much good to anybody. This trans-
10 cript should be available on the night of the hearing
11 and not later than the following morning.

12 Next, with respect to the general subject
13 matter and the observations which I make are my own.
14 This Committee as we progress, will speak as a body
15 because this is not an effort by the Chairman. Our
16 inquiry will be the efforts of the entire Committee as
17 a whole. It would appear obvious to me that some of
18 the information which we would hope would be available,
19 and may be available to us would deal with such matters
20 as, for instance, the drug bill in Ontario, as a
21 simple proposition.

22 May I digress again and state, it is our
23 intention after this preliminary hearing this week to
24 have counsel for the Commission and further we have
25 retained the services of Mr. Ayers, a partner in the
26 firm of chartered accountants Messrs. Sime Ayers and
27 Company who will be available to the Commission for
28 assignment on such matters as we may direct.

29 The cost of drugs, of course to me and as I
30



1 stated these are my own observations only, and made with
2 a view to moving the Committee and getting it started,
3 but the cost of drugs to me is not restricted or confined
4 to a dollar figure. I would think that a reasonable
5 interpretation of the cost of drugs would involve such
6 factors as wastage, obsolescence, over-prescribing,
7 problems of storage and so on.

8
9 Now the drug bill in Ontario there may be some
10 difficulty to ascertain; some reference will have to be
11 made to the figures of the Dominion Bureau of Statistics,
12 but we certainly should have some figures as to the drug
13 bill in this Province in relation to the National drug
14 bill.

15 I do not presume to suggest the basis on which
16 those figures be prepared at this stage, but certainly
17 the manufacturers and the sellers of so called drugs
18 may very well be able to assist. I would think that
19 the drug bill in Ontario might well be compared on a
20 per capita basis with the drug bill in other provinces
21 and indeed, with any other information of other
22 jurisdictions which would be of assistance to us.

23 The question of prescription costs becomes
24 somewhat involved in the sense I have no knowledge as
25 to whether any records exists of the number of prescriptions
26 actually issued in hospitals or to outpatients, but I
27 would think we are interested in what the average
28 prescription costs are.

29 Similarly, we proceed to a definition of the
30 word "drugs". I would hope that in this early hearing



1 we would have defined for us drugs and certainly the
2 things that come to mind to a layman, for some reason,
3 we think of narcotics. I do not think narcotics by
4 their nature are particularly before this Committee, but
5 there certainly would be other categories possible under
6 the heading of medication, including sedatives. There
7 would be a sub-category of antibiotics. I am told that
8 a desirable name of another category would be psycho-
9 torpics and tranquilizers, and so on, but in any event
10 I would think that some effort of definition is required
11 for us to know just what we are talking about and where
12 these various items, manufactured items, are available
13 and we look to you, the public, and interested parties
14 to assist us.

15 Of course we are interested in the purchase
16 methods of hospitals. We are interested in the control
17 of purchasing and the methods. We are interested in
18 whether or not in hospitals there exists a price list
19 of drugs for use in that hospital, and in the factor as
20 to how items are added to that list, and thereby,
21 directed through the purchasing department.

22 I would think that we are interested in the
23 situation of the dental factor. I am told that there
24 may be some difficulties, but by the same token it may
25 be, for all I know, that category may be excluded before
26 we start, in the sense, that apart from the daily use of
27 freezing compounds, and such, and please forgive my
28 lack of knowledge of the vocabulary on this subject, but
29 apart from those items which are in daily use by the
30



1 dental profession, it is possible that the actual
2 prescribing of drugs which is a right enjoyed by the
3 dental profession, it may not be exercised a great
4 deal, having in mind the possible reference of the
5 patient to the medical profession, but I would think
6 that that matter should be dealt with and explained.

7 We of course are interested in not only the
8 over-all figures and statistics, but our attention will
9 certainly be directed to certain drugs, so called drug
10 items which are mainly described as expensive.

11 We will be interested in the selling out costs
12 which prevail in hospitals themselves. The selling out
13 costs which goes with respect to in-patients, and I use
14 that phrase advisedly, because in-patients may or may
15 not be covered by private insurance and they may or may
16 not be covered by our Ontario Hospital Scheme, but in
17 any event, we know that some 90% of the people in
18 Ontario are covered by the scheme and therefore, 90% of
19 the drug bill of in-patients is picked up by the public
20 purse; therefore, obviously, a matter of interest to
21 us.

22 However, then on the out-patients side, there
23 is the uninsured category of out-patients and what
24 charges are made to them, and the entire body of out-
25 patients and the cost of drugs that they may have to
26 bear.

27 With respect to the hospitals themselves,
28 the Committee will expect to have produced to it certain
29 price lists offered by those in the business of selling
30



1 the so called drugs, and I would think on that score
2 that we will want to compare the prices that those
3 people offer, compare their price list here in Ontario
4 with their price list in other jurisdictions, including
5 other provinces, possibly the United States, and
6 possibly the country or jurisdiction where their parent
7 company, if any such exists, operates.

8 MR. SUTTON: Mr. Chairman, at this point may
9 I ask a question?

10 THE CHAIRMAN: You may.

11 MR. SUTTON: You have failed to point out
12 that this Committee would be interested in the price of
13 drugs to drug stores and from drug stores to the public.
14 Are our terms of reference broad enough to take that into
15 account?

16 THE CHAIRMAN: It was not my intention.

17 MR. SUTTON: It is only the Ontario institutions
18 themselves as to the price of drugs to the public
19 generally?

20 THE CHAIRMAN: The inquiry is directed
21 primarily to the cost of drugs to the hospitals and the
22 institutions, as to primarily whether or not they are
23 fair and reasonable.

24 I will say that I would think that our terms
25 of reference would include certain comparisons which might
26 include, as you state, the drug stores.

27 The reason that I am outlining this subject
28 matter is because of the number of inquiries which I have
29 received during the past six weeks. I would think that
30



1 there would be a very healthy discussion from various
2 sources about the subject of trade as against generics
3 and trade descriptions, trade name and generic descrip-
4 tions, we will be very much interested in that. I
5 would think that figures of comparisons such as drug
6 costs and drug bills should be compared over a five, ten
7 year period, and I would ask those who are preparing
8 such information to keep that in mind.

9
10 There are certain other factors which may
11 contribute to an increase or decrease in the cost of
12 drugs having to do with such matters as what is
13 described as increased quantities factors. The changed
14 proposition or changing proposition of goods; increased
15 or changed quantities of ingredients and certainly a
16 packaging factor which will be obvious to you.

17 It will certainly be under discussion, and I
18 would assume will be raised, the research factor on this
19 subject and the relationship of profit against cost.
20 Probably there will be, I would hope, some information
21 about proprieties which have no equivalent and similarly
22 with respect to equivalents which cost less than a
23 specific propriety, and equivalents which cost more than
24 a specific propriety.

25 I don't know whether there is any information
26 available with respect to doctors' prescribing costs in
27 this jurisdiction. I would be interested to have,
28 certainly, a statement on the extent to which doctors
29 prescribe today, and when I say "prescribe" I mean
30 make up prescriptions in their own laboratories, and that



1 should involve a comparison over the last ten, fifteen,
2 twenty or twenty five years.

3 I would expect some information to be made
4 available with respect to the doctors' right to prescribe
5 and I have already referred to the research factor and
6 we should consider that under the heading of private
7 research by private or non-public or corporate companies,
8 shall I say, as against the relationship of government
9 sponsored bodies such as the Connaught Laboratories.

10 I think we would also be interested in what
11 constitutes clinical trials and what accomplishes the
12 acceptance of a new drug. What is the proof in drugs.
13 Also the question of restrictions of quantities which
14 are prescribed. How is that controlled?

15 Now with respect to the pharmaceutical companies
16 I think it would be very helpful if a list were prepared
17 for the Committee giving the names and identifications
18 of all of those companies which are in the business of
19 selling so called drugs to hospitals. With an iden-
20 tification on the subjects on these points: are they
21 agents only? Are they simply selling agents? Are they
22 manufacturers? Do they do their own research work?
23 Do they operate under patent? Under licence? Under
24 agreements and I mean patent agreements. Are they
25 privately or publically owned? Are they subsidiaries
26 of other companies in or out of this jurisdiction?

27 Now this is not an attempt to be all-inclusive
28 but it is an effort to make some statement to you of some
29 of the things that are going through the minds of the
30



1 members of the Committee, and with that amplification
2 I think we will proceed with our work. We will
3 probably have an opportunity for a further statement
4 this week with respect to the scope of the inquiry.
5 Now may we Mr. Secretary proceed and call for appearances?
6 Would those who have an interest in this hearing please
7 identify themselves for the record?

8 THE SECRETARY: I believe we have got a
9 number of the attendance forms, but if you would mind
10 standing and letting me have your names so we can mark
11 your attendance. Would you rise please and tell us
12 your name.

13 Mr. A. L. Fleming for the Ontario Hospital
14 Association.

15 Mr. S. W. Martin, Ontario Hospital Association.

16 Mr. J. Irwin Smith, Drug Merchandising,
17 MacLean-Hunter.

18 Miss G. Eileen Wellman, Drug Merchandising,
19 MacLean-Hunter.

20 THE CHAIRMAN: Mr. Robinette?

21 MR. ROBINETTE: I am just observing today.
22 I am just watching to see what the timetable is. I don't
23 know whether I will be appearing for anyone or not.

24 THE CHAIRMAN: Mr. Robinette in his personal
25 capacity. Mr. Pattilo?

26 MR. PATTILO: Mr. Chairman, I and my
27 partners, Mr. Simpson and Mr. Brown, from my firm are
28 here. Our firm represents a number of companies that
29 are engaged in the drug business in Ontario. Whether
30



1 or not they are going to be concerned with this inquiry,
2 I think it is too early for us to tell and we are here -
3 we are told to come here and observe at this stage. At
4 a later stage we will be prepared to say for whom we are
5 appearing, but we do not think it is advisable to do so
6 at this stage.

7 THE CHAIRMAN: Is there any other appearance
8 to be made? This is not a matter of a Sunday School
9 attendance. This is a matter of assisting the Committee
10 to know what arrangements should be made with respect to
11 the procedure. I see some representatives of the
12 Ontario Department of Health.

13 Dr. W. G. Brown, Deputy Minister of Health.

14 Mr. Stefan Grzybowski, Ontario Department of
15 Health.

16 Dr. Donald R. Gunn, Mental Health Division.

17 Mr. G. G. Brooks, Ontario Attorney General's
18 Crime Laboratory.

19 Dean F. N. Hughes, Faculty of Pharmacy,
20 University of Toronto.

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THE CHAIRMAN: Are there any others who wish to record their appearance? Very well, we shall proceed with our first presentation from the Ontario Department of Health, Dean Hughes of the College of Pharmacy.

DEAN F. N. HUGHES: Mr. Chairman and Members of the Select Committee: May I first say that my presentation is not very brief and if when we get to the halfway point you would like to pause then I am quite agreeable.

May I also say initially that I regret I have not provided a definition for drugs. I have gone on the assumption that the definition which is in the Pharmacy Act would probably be sufficiently all-embracing for the Terms of Reference of this Committee. However, should you wish a definition later, we shall be glad to provide it for the benefit of the Committee.

It would seem desirable that two points should be established at the outset. I appear before you at the request of the Minister for the express purpose of providing factual background information respecting the development of the profession of pharmacy; and also to outline some of the dramatic changes which have taken place in the nature, the methods of development and the actual use and usefulness of drugs in this generation. It is the Minister's thought, and I agree with him implicitly, that any investigation into any aspect of drugs can only properly be held against a background of knowledge such as this. Some public



1 statements which have been given wide publicity in
2 recent months have been made by persons and quoted or
3 printed by others without an apparent knowledge or at
4 least appreciation of this type of basic knowledge.

5 I am sure it is the earnest hope of this Committee that
6 its findings will be made soberly and soundly having due
7 regard to all factors involved and, most particularly,
8 the best interests of the public in respect to matters
9 of health.

10
11 The second point I should establish is that
12 this presentation will be as factual as I can make it.
13 Our prime concern as in any school of pharmacy is that
14 those who graduate have the essential education to meet
15 in full their responsibilities to the community, regard-
16 less of the branch of Pharmacy in which they choose to
17 serve. Because of our position, then, we are able to
18 view with reasonable objectivity the entire broad field
19 of this vocation, or rather group of vocations, which
20 is concerned with drugs and what is called "the science
21 of medicaments". I feel it is necessary to say that
22 I cannot view the profession disinterestedly. Anyone
23 who is close to it realizes something of the contri-
24 bution which Pharmacy has made to public health over
25 the centuries, and the even greater contribution being
26 made in this century, and therefore cannot be dis-
27 interested. But that does not lessen in any degree
28 the objectivity which pharmaceutical educators have
29 traditionally brought to bear on and about the pro-
30 fession. As with other professions, the educators



1 feel it is their special privilege, in fact, their
2 bounden duty -- to admonish the practitioners and to
3 recount to them their sins of omission and commission.
4 I think it is because of his knowledge of that object-
5 ivity that the Minister invited me to make this sub-
6 mission today.

7
8 Most adults today are aware that there have
9 been rather important developments in drugs in recent
10 years. It is likely, however, that very few of those
11 outside the health professions have any real concept
12 of the magnitude of the effects which these develop-
13 ments have had upon either public health or upon the
14 health professions themselves. It is even more
15 unlikely that many are aware of the forces which brought
16 about these changes, forces which have created a
17 structure which has the potential to continue to pro-
18 duce dramatic results for the welfare of mankind.

19 It is safe to say that the electronic develop-
20 ments of the past few decades, great as they have been,
21 have not produced more radical changes in their own
22 way than have the changes in drugs as tools for the
23 treatment of disease have in theirs. While the former
24 have speeded up many tasks and have greatly widened the
25 field of entertainment, the startling developments in
26 drugs have saved countless lives in the past 2 decades
27 and lengthened the life span by more than twenty years
28 since 1900. Prior to 1900 for 300 years, the life span
29 had only been lengthened some 14 years. In the course
30 of doing so the nature of the practice of pharmacy has



1 been altered to such a degree that the academic prepara-
2 tion for it has had to be drastically changed to meet
3 the challenge of the age of "wonder drugs". Let us
4 briefly outline some of the highlights in the history
5 of drugs and pharmacy in order to point up the current
6 situation especially as it relates to the modern role
7 which this profession is playing in the field of health.

9 Today we recognize clearly the distinction
10 between the medical practitioner, whose function it
11 is to diagnose and to prescribe treatment for illness,
12 and the pharmacist whose role in the broad sense, as an
13 expert on drugs, is to be responsible for the prepara-
14 tion, testing, preserving, compounding and dispensing
15 of drugs, i.e. of substances used in the diagnosis,
16 prevention and treatment of disease. That is the
17 closest I have come to a definition. At one time,
18 however, the same person in the community performed
19 both functions. In some early civilizations the
20 religious leaders combined the treatment of disease,
21 including the preparation of crude medicines, with
22 their religious practices. Primitive man was
23 probably intensely superstitious, looked upon disease
24 (which he could not understand) in fear, attributing
25 it to evil spirits. Little wonder, then, that some
26 vestige of superstition attended man's view of disease
27 and treatment until our understanding of both rested
28 on a firm scientific foundation. Some of you will
29 still recall the wearing of asafoetida or gum camphor
30 around the neck perhaps by your grandmothers to prevent

1 colds.

2 The first "drugs" were probably discovered
3 by primitive families in the search for food to be
4 given to sick patients. Perhaps herbs or barks or
5 leaves or roots, then were prepared by women who cooked
6 them with water and gave them to the sick as they would
7 food. When the patient recovered, credit may have been
8 given to the concoction or to the method of preparing
9 it or to the time of the year or the phase of the moon
10 when it was gathered, despite the fact that more often
11 than not it had nothing to do with the recovery. The
12 strong motivation by the cause and effect relationship
13 did not enable the early users to distinguish between
14 drug action and coincidence. Lest we scoff at pre-
15 historic man's attitudes, it is worth noting that the
16 twentieth century has seen much of this same attitude,
17 especially before the "materia medica", that is materials
18 used as medicine, which has been developed in the past
19 twenty-five years. Before leaving this aspect of the
20 early discovery and use of drugs, it is significant to
21 point out that the original association between foods
22 and drugs has persisted to modern times. Undoubtedly
23 man came to recognize that foods were materials consumed
24 to maintain health and energy, while drugs were sub-
25 stances used to restore health and energy. Our
26 Canadian Food and Drugs Act reminds us of our modern
27 recognition of this early relationship. But today
28 most drugs are so much more potent - hence dangerous
29 when misused -- that practically no real resemblance to
30



1 foods exists any longer.

2 From the dawn of recorded history through
3 successive near-eastern civilizations of Babylon
4 (4000 years B.C.), Egypt, Greece and Rome, varying
5 degrees of superstition, faith and empiricism, that
6 is, the trial and error system rather than the
7 scientific method, governed the treatment of disease.
8 The Greeks, Hippocrates especially, introduced a
9 measure of rationalization into the treatment of the
10 sick by recognizing the importance of rest and fresh
11 air to recovery. During the Greek era, we learn of
12 some who were "root diggers", others who were com-
13 pounders of medicine, in addition to physicians who
14 treated patients, but there was much overlapping of
15 function. Galen in the second century A.D. regularized
16 the materia medica of the day by publishing treatises
17 on the preparation of herbal remedies, solutions of
18 plant constituents and other mixtures not involving
19 chemical reaction. Such preparations are still called
20 "galenicals". Galen's concepts dominated the drug
21 therapy of disease for more than a thousand years. In
22 fact residues of his precepts are still to be found in
23 this century although most of the preparations had little
24 or no value. I emphasize this to indicate again how far
25 we have come in a short several decades of modern
26 scientific pharmacy and medicine.

27 The separation of the compounder, or drug
28 specialist, and the physician could not be made until
29 a government recognized that there was need for both
30



1 physician and apothecary and that it was in the interest
2 of public health that neither should do the work of the
3 other. This occurred in 1240 A.D. when Emperor
4 Frederick II of Hohenstaufen, Kingdom of the Two
5 Sicilies (and Holy Roman Emperor) issued a decree that
6 pharmacy should be separated from medicine as each
7 required the exercise of separate special skills and
8 knowledge.
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His edict:

- (i) forbade business relationships between the two (that is what have come to be called, among other things, "kickbacks");
- (ii) established a system of inspection of premises selling drugs;
- (iii) directed that the apothecary prepare medicines according to a formulary used in the Salernian School of Medicine;
- (iv) limited the number of pharmacists by population -- this affected later the Germanic and Italian areas of Europe, but not the French and English regions.

The establishment of a separate group of compounders and sellers of drugs set the stage in time for the development of an awareness of the need for medicines of more consistent uniformity. So formularies and pharmacopoeias (i.e. official books containing descriptions of drugs and medicines with standards to which they must conform) bearing the endorsement and authority of at first a city government (the first of Florence, Italy, 1498) and later national governments (London 1618, Edinburgh 1679, Dublin 1807 became British Pharmacopoeia in 1864). The growth of the guild system in Italy, France and Britain during the late Middle Ages laid some emphasis upon standards of qualification for entrance to the practice of the various professions and also in the case of apothecaries' guilds, gave some emphasis on standards for drugs. This, together with



1 the development of a scientific attitude toward drugs
2 in France and Germany with emphasis on pharmaceutical
3 chemistry as opposed to what might be termed galenical
4 pharmacy resulted in the beginnings of "plant chemistry".

5 Reasoning that drugs should be pure in order
6 that results might be reproducible, the first extrac-
7 tion studies were carried out on plants containing
8 potent substances. Thus, in the early 19th Century,
9 Serturner isolated the alkaloid, morphine from opium,
10 and Pelletier and Caventou recovered quinine and
11 strychnine from extracts of cinchona bark and nux
12 vomica respectively. The isolation of these pure
13 crystalline chemicals (alkaloids) from crude drugs
14 was one of a series of developments which ultimately
15 have revolutionized pharmacy. Until then, crude drugs
16 of varying purity and potency were sold as such in
17 the apothecary shops. They were also used by the
18 apothecary to make extracts, tinctures, etc., which were
19 also of uncertain composition, and, in most instances,
20 relatively ineffective. Now for the first time the
21 active principles of several at least were available
22 in pure form. Yet progress was slow. In the 1914
23 edition of the British Pharmacopoeia, more than 100
24 years later, out of 109 plant drugs described, assays,
25 that is the chemical analyses, based on isolated active
26 principles numbered only 5. Other discoveries had
27 still to come.

28 Various discoveries starting with those
29 described above during the 19th century produced a
30



1 gradual awakening scepticism respecting traditional
2 empiricism and irrational multiple mixtures of
3 medicinal substances. I wish there was time to
4 illustrate a number of those; they are priceless.
5 The dawn of organic chemistry with the laboratory synthe-
6 sis of the animal compound, urea, in 1828 was an im-
7 portant cornerstone for the modern structure which
8 did not begin really to take shape for 100 years. Pasteur's
9 discovery of microorganisms as the cause of infectious
10 diseases, Lister's introduction of antiseptis, the
11 development of antitoxins and the much earlier demon-
12 stration of vaccination were all important foundation
13 blocks for the structure to come. The most important
14 of all was the work of Dr. Paul Ehrlich who was, in
15 effect, the "father of chemotherapy". We shall come
16 back to him in a moment.

17
18 Let us pause now and regard pharmacy and
19 drugs in Ontario at the beginning of the present
20 century. The Pharmacy Act of 1871 with subsequent
21 amendments established the Ontario College of Pharmacy
22 as the statutory body to examine candidates for the
23 licence to practise pharmacy in the Province. The
24 College was also given the right to establish a teach-
25 ing school, which was done in 1882 and which ceased
26 to operate only in 1953 when the University of
27 Toronto established the Faculty of Pharmacy. The
28 Pharmacy Act was designed to safeguard the public by
29 assuring that drugs, medicines and poisons would be
30 compounded and sold by qualified persons who were



1 cognizant of the dangers inherent in each. Five years
2 of study were required, four years as apprentice and one
3 year at College -- the longer practical period because
4 in 1900 the actual preparation of medicines mainly
5 involved technical operations which could best be learned
6 under a preceptor. In 1904 -- we selected that date
7 because that was the beginning of a pharmacy where we
8 obtained some figures I am going to quote from.
9 There were nearly 1,000 pharmacists serving a popula-
10 tion of just over 2,000,000. Practically all of these
11 were engaged in the practice of retail pharmacy. A
12 few pharmacists were employed in hospitals and the
13 industry was many times smaller than at present. Hence,
14 pharmacy then was practically synonymous with retail
15 pharmacy.

16 The type of medication prescribed at that
17 time is represented by the 15 consecutive prescrip-
18 tions listed below from the files of a Toronto pharmacy,
19 they are on the next page. The emphasis is on tinctures,
20 spirits, elixirs, and some inorganic salts. Only on
21 trade-name preparation is included and it is only a
22 mixture of several common salts. At least twelve
23 of the fifteen required compounding by the pharmacist.
24 While a few of the drugs are still used today
25 (e.g. morphine, codeine, sodium salicylate, digitalis,
26 ergot) they are now used in more effective forms or
27 combinations. None of the drugs was developed as a
28 result of any of the type of research which was to come
29 later. Most of the chemical ingredients would have
30



1 been purchased. The galenical preparations, such as
2 tinctures, solutions, etc., could have been purchased
3 from any of several manufacturing companies which were
4 then in existence, but most would have been prepared
5 in the dispensary. It should be noted that spelling
6 errors are as they appeared on the prescriptions.
7 I mention that for the benefit of pharmacists who
8 might be with us.

9 I am not going to take any time in going
10 over those.

11 I might say for the record we omitted names
12 of the drugs which did not seem to be relevant.

- 13 1. \mathcal{R} Morph. Sulph. gr. i
14 Codia gr. ii
15 Elixir Heroin 3i
16 Mellis 3iv
17 Aquam ad 3iiii
18 2. \mathcal{R} Ammonal Tabs. gr. v
19 3. \mathcal{R} Sodii Salicyl. 3v
20 Elixir Lactopeptine
21 Tr. Card. Co.
22 Glycerin aa 3i
23 Aqua ad 3iv
24 4. \mathcal{R} Tr. Ferri Mur. 3iv
25 Quin. Sulph. 3ss
26 Liq. Strychnine 3iss
27 Syr. Simplex 3ii
28 Aqua ad 3vi
29
30



1			
2	5. R/	Pot. Citrate	3iv
3	6. R/	Sp. Aeth. Nit.	3ii
4		Tr. Nuc. Vom.	3ss
5		Syr. Aurant	3iv
6		Aq. ad	3ii
7	7. R/	Pot. Sulphurata	
8		Zinc. Sulphurata	
9		Sulphur Ppte. aa	3i
10		Aqua Rosae q.s. ad	3iv
11	8. R/	Quin. Sulph. gr.	iss
12		Salol gr.	iiss
13	9. R/	Ung. Zinc. Ox.	3i
14	10. R/	Tinct. Nux Vomica	
15		Tinct. Cantharides aa	1 dr.
16		Tinct. Ferri Mur.	3 drs.
17		Fl. Ext. Ergot	1 oz.
18		Acidi Phos. dil.	3 drs.
19	11. R/	Liq. Ferri Pept. et Mang. c Arsenic	3vi
20	12. R/	Sod. Bicarb.	3ii
21		Sodii Salicyl.	3ii
22		Tinct. Nuc. Vom.	3ii
23		Syr. Zingib.	3iii
24		Aq. Menth. Pip.	3viii
25	13. R/	Elix. Glycerophos (Comp.) Wyeth	3i
26		Elix. Lactopep.	3i
27	14. R/	Tr. Digitalis	3ii
28		Tr. Nuc. Vom.	3i
29		Elix. Simp. ad	3iv
30			



15. R/	Liq. Strych.	311
	Acid Nitro mur.	311
	Tr. Gent. Co.	311
	Aq. ad	31v

The average fee charged for prescriptions in 1900 was about 50 cents, the range of charges being largely 25 cents to \$1.00, with an occasional one costing up to \$3.00. The following chart offers an interesting group of comparisons. It is interesting to see the increases over the period in these instances are relatively similar.

Approximate Average Prices in Ontario

	<u>Prescriptions</u>	<u>Sirloin Steak</u>	<u>Bread</u>
1900	* 50¢	14¢	3.7¢ lb.
1958	# \$2.97	98¢	15¢ lb.

Men's Suits (wool)

1900	\$6.00 to \$12.50
1958	\$50.00 to \$100.00

* based upon prices in an Ontario town.

Canadian Pharmaceutical Association Annual Survey (H. J. Fuller).

Food and clothing prices, 1900, supplied by Toronto Reference Library.

I did have some slides that I might have shown this morning showing a pharmacy of those days, but we can omit them without losing anything, I believe.



In 1930

In 1930, we again come to the descriptions in the preparation of drugs. By 1930, although little outward sign of great change was evident in the types of medication available, fundamental underlying developments were occurring in preparation for what was to come. Yet no one -- and I say this with conviction because I was in the practice of Pharmacy in 1930 -- would have dared to predict that the next three decades would see an amazing revolution in drugs, hence in pharmacy and medicine. Again a study of 15 consecutive prescriptions from the identical Toronto pharmacy reveals somewhat fewer galenicals were prescribed, a few more trade name preparations were listed including several incorporating the results of pharmacological and clinical research. Ten of the prescriptions required compounding, which are rarely used today. No barbiturates were included in this small number but occasional prescriptions for one of the early ones were written in 1930. The favoured sedatives of that period were bromides. All but 4 of the prescriptions could have been filled in 1910. That is a significant point, that over twenty years that there has been that little change.

The average fee charged for these prescriptions in 1930 was about 67¢.

Presenting these prescriptions, I would like to mention that prescriptions that have changed



1 in the different methods employed in their preparation.
2 A great many mixtures have been used which are now
3 recognized to be valueless. In those days you could
4 not combine syr. trip. phosphate. Calamine was a
5 cathartic which was used very frequently. Very often
6 a rhubarb mixture was also used. This also contains
7 other drugs which are practically never employed
8 today.
9

- | | | | | |
|----|-----|----|-----------------------|---------|
| 10 | 1. | R/ | Soln Pilocarpine | 1/2% |
| 11 | 2. | R/ | Sod. Brom. | 3i |
| 12 | | | Tr. Digitalis | 3ii |
| 13 | | | Tr. Bellodonna | 3i |
| 14 | | | Syr. Aurantii | 3i |
| 15 | | | Aq. ad | 3vi |
| 16 | 3. | R/ | Liq. Plumbi Subacetat | |
| 17 | | | (Fort | 3i |
| 18 | 4. | R/ | Calc. Carb. | gr. x |
| 19 | 5. | R/ | Elix. Scyan | 3iv |
| 20 | 6. | R/ | Maltlevol | 3iv |
| 21 | 7. | R/ | Ferro Catalytic | |
| 22 | 8. | R/ | Sod Brom. | |
| 23 | | | Am Brom. | aa 3iss |
| 24 | | | Tr. Gentian Co. | 3ss |
| 25 | | | Kasagra | 3ii |
| 26 | | | Ess. Caroid | 3iii |
| 27 | | | Aq. | ad 3vi |
| 28 | 9. | R/ | Pot. Chlor. | 3iii |
| 29 | | | Aq. Menth Pip | ad 3iii |
| 30 | 10. | R/ | Tab. Codeinae | gr. ss |



11. R/	Pot. Cit.		3i
	Tr. Hyoscyamus		3iv
	Palatine		3iv
	Aq.	ad	3iv
12. R/	Syr. Trip. Phos.		
	Syr. Phos. Co.	aa	3ii
13. R/	Cod. Phos.		gr. 1/2
	Antipyrin		gr. iv
	Caff Cit		gr. i
14. R/	Lotio Calaminae		3iv
15. R/	Tab. Codia		gr. 1/2

In the period between 1920 and 1930 a swing away from plant drugs of uncertain composition was taking place steadily. The science of pharmacology was developing. Physiology and biochemistry were advancing. More was being learned about the action of drugs on the body. Insulin had been discovered. Liver Extract therapy of pernicious anaemia had commenced. But there were still prescribed many of what were later shown to be relatively ineffective medicines.

Graduates, now of a longer course in pharmacy, were finding more positions in hospital pharmacies, and with manufacturing companies which were becoming more active in a developmental way as research in physiology, biochemistry, bacteriology, chemistry and pharmacology was increasing. The age of empiricism was near its end. Let us go back for a moment to see how the manufacturing pharmaceutical industry, which was soon to play such a vital role, originated.



Beginnings of the Pharmaceutical Industry

It may be said correctly that the pharmaceutical industry had its beginning in the apothecary's compounding room. However, basically, the apothecary merely prepared medicines for his own shop. With the isolation of some of the alkaloids and the increasing awareness of the need for consistency and purity in drugs in the 19th century, certain enterprising apothecaries began to make a specialty of producing certain products on a larger scale for sale to other pharmacists. The German pharmacist, Merck of Darmstadt, began in this way with morphine. Allen and Hanburys of England, and Schering of Germany had similar beginnings. On this continent, Parke, Davis & Co. sprang from a pharmacy where Cascara had its origin. Lilly, Smith Kline and French and Wyeth had similar beginnings, while Upjohn, Squibb and Lederle were initiated by physicians for similar reasons. In each case the desire to make one or a few products just a little better and on a larger scale was the incentive. In the 19th and early 20th centuries these and other companies developed rather slowly as the type of research possible was limited. At first, new plant drugs were searched for, improved flavouring of medicines was studied, but most products, extracts, tinctures, ointments, pills, etc., were strictly competitive among the companies. Some specialized in biologicals, like antitoxins, others concentrated on elixirs and effervescent salts. But the real role of the industrial branch of pharmacy had



1 to await the era of "scientific medicine" which began
2 with Paul Ehrlich around the beginning of this
3 century, and reached a point of rapid acceleration
4 in the late 1930's.

5 The New Therapeutic Era

6 Ehrlich's greatest contributions to medicine
7 were two concepts which he was able to prove: (i) that
8 specific drugs could be developed in the laboratory to
9 treat specific diseases, and (ii) that research
10 for new medicaments was a team effort involving chemists,
11 pharmacists, pharmacologists, biochemists, physicians,
12 and scientists of other branches of pure and applied
13 science. Ehrlich set out to synthesize a series of
14 compounds to find one which would act specifically
15 against syphilis yet would not poison the patient.
16 His 606th experiment was successful as he produced
17 Salvarsan, which was called "Salvarsan", by the way,
18 and later Neo-Salvarsan, organic arsenical compounds
19 which were used for many years. Thus was founded
20 "chemotherapy" wherein the laboratory became a powerful
21 weapon in the fight against disease.

22 Reference was made earlier to the first
23 organic synthesis by Wohler in 1828, that is the
24 manufacturing in the laboratory of the chemical
25 compound which ordinarily was only a mixture. In
26 the latter part of the 19th and early 20th centuries
27 more and more new compounds were made in the laboratory.
28 Some of them were found to have useful drug actions. The
29 use of coal tar as a source of such synthetics resulted
30



1 in the introduction of a large number of compounds,
2 including aniline dyes and others which have become
3 very important in medicine -- e.g. acetylsalicylic acid
4 (Aspirin is one brand) as a classical example.
5

6 Ehrlich's success stimulated increased
7 activity in synthetic dye and other laboratories in
8 Germany and elsewhere in the search for compounds which
9 might combat other infections. Among the thousands
10 synthesized two were reported in 1908 and 1909
11 respectively, sulphanilamide a white crystalline sub-
12 stance, and a red dye patented under the name of Pron-
13 tosil. These were just put away on the shelf.
14

15 -

19 -

24 -

28 -



md 1 It was not until 1935 that the world learned of the
2 success of experiments by Gerhard Domagk in 1932 wherein
3 Prontosil had cured streptococcic infections in mice, and
4 and also incidentally, in a heroic experiment, in his
5 daughter. French investigators discovered that the
6 simpler compound, sulphanilamide, was the therapeutically
7 effective component in the Prontosil molecule. Thus was
8 launched the modern era of miracle drugs. Prior to this
9 no drug taken into the body had acted effectively against
10 common disease-producing organisms, such as staphylococci
11 and streptococci, without also endangering the life of
12 the host. Sulphanilamide, the first of a long list of
13 sulphonamide compounds, was a true chemotherapeutic
14 agent, which opened the door to many new categories of
15 synthetic therapeutic agents.

16 Those of us who have lived through the develop-
17 ments since that time will never cease to marvel at the
18 miraculous progress which has been made. There have
19 been: Penicillin introducing the antibiotics; Benadryl
20 the first of the antihistamines for allergy and the
21 indirect precursor, too, of the tranquilizers and
22 psychotropic drugs; the corticosteroids for arthritis;
23 vitamin B₁₂ the most potent anti-anaemic substance known;
24 by the way, one millionth part of a grain - and it
25 would take a thousand of these to be able to see very well,
26 just a tiny pinpoint, is sufficient to maintain a
27 pernicious anaemia patient for a day. The Salk vaccine;
28 oral antidiabetic drugs and a host of others. This has
29 happened and will continue to happen because no longer is
30



1 man content to accept drugs which he discovers by trial
2 and error in nature. Rather to-day he sets out in the
3 laboratory to prepare specific synthetic compounds with
4 chemical structures such as might be expected to have
5 specific types of activity in the body. This system
6 yields many more active and therapeutically useful
7 compounds in a shorter time. Also, many thousands of
8 substances are produced, - this is important for your
9 consideration, Mr. Chairman. Many thousands of
10 substances are produced, tested and found to be of no
11 value or too toxic. It has served to replace the bulk
12 of the relatively ineffective medication of the 20's
13 with potent life-saving compounds.

14 THE CHAIRMAN: Dean Hughes, I wonder if this
15 might be a convenient spot to have a five minute recess.

16 DEAN HUGHES: Absolutely, sir.

17
18 --- SHORT RECESS

19
20 --- UPON RESUMING AT 11:40 A.M.

21 THE CHAIRMAN: Dean Hughes, would you care to
22 resume, please.

23 DEAN HUGHES: Mr. Chairman, we have prepared
24 and presented a comparison of a number of a certain class
25 of drugs which have been described and shown in the
26 British Pharmacopoeia between 1898 and 1958.

27 They reveal a rather striking change ~~has taken~~
28 place and by referring to that table we find that plant
29 drugs and tinctures extracts are out and they appear to
30 almost have passed out of the picture.



For example, in 1898 there were 188 plant drugs illustrated in the Pharmacopoeia and in 1958 there were 16.

Then on the other hand, in 1898 in the Pharmacopoeia there were 11 organic synthetic drugs - 11 - and in 1958, there were 156. That is not all of them that are used. That is only the official ones.

It is apparent that the only plant drugs remaining are those which contain well-defined therapeutically active compounds. We have not thus far referred to other naturally occurring drugs, those of animal origin. In this category are the extremely valuable so called hormones, some of which or similarly acting compounds are now prepared synthetically.

You will also note that in 1898, it was only necessary to revise the British Pharmacopoeia sixteen years after date. Now there are revisions every five years and a supplemental addendum in between.

Comparison of Prescriptions 1904 to 1960

On page 8 and 10 are listed 15 consecutive prescriptions from the files of a Toronto pharmacy in the years 1904 and 1930 respectively. Below are similar groups from 1945 and 1960 together with a following summary of those from all four periods.

1945

1.

R

Ichthio. min x
Lotio Sulph Co. 3vi
(C.F.)



- 1
2. \mathcal{R} Liq. Alumin. Acetatis
C.F. 3viii
- 3
- 4 3. \mathcal{R} Thy. Ext. Dess.
(P.D. & Co.) gr. 1/2
- 5
- 6 4. \mathcal{R} T.T. Nitroglycerin
fr. 1/100
- 7
- 8
- 9 5. \mathcal{R} Nembutal gr. iss
- 10
- 11 6. \mathcal{R} Tab. Barbital gr. v
- 12
- 13 7. \mathcal{R} Benzedrine Sulphate
Tabs. 10
- 14
- 15
- 16 8. \mathcal{R} Sol. Metaphen 3ss
1-2500
- 17
- 18
- 19 9. \mathcal{R} Sulfadiazine gr. viiss
- 20
- 21 10. \mathcal{R} Sulfadiazine gr. 7.7
- 22
- 23 11. \mathcal{R} Nitroglycerin gr. 1/100
- 24
- 25 12. \mathcal{R} Sulfopto 3ss
- 26
- 27 13. \mathcal{R} Neo-Synephrin.
emulsion 1/4%
ad 3i
- 28
- 29
- 30 14. \mathcal{R} Sulphathiazole



- 1
- 2 15.
- 3 R
4 Tabs. Hypnolone gr. 1/4
5 1960
- 6 1.
- 7 R
8 Gantrisin Ped. Susp.
9 3iii
- 10 2.
- 11 R
12 Proloid gr. ss
- 13 3.
- 14 R
15 Cortisporin Ointment
16 1/2 oz.
- 17 4.
- 18 R
19 Vibutasy1 Caps. 100
- 20 5.
- 21 R
22 CEL-O-DEX Tabs. 100
- 23 6.
- 24 R
25 Forpen 800,000 units
- 26 7.
- 27 R
28 Duapen-200 Ayerst
29 Mitte vi
- 30 8.
- 31 R
32 Hylenta Tablets
33 Ayerst #888
34 Mitte xii
- 35 9.
- 36 R
37 Atrostigmin Tablets
38 30
- 39 10.
- 40 R
41 Dulsana Mild
42 4 fl. oz.
- 43 11.
- 44 R
45 Sulfadiazini gr. viiiss
46 Tabs. xviii



12.

R

Diuril 500
Mitte xii

13.

R

Pentids-600 Tabs.
Mitte 36

14.

R

Sod. Amytal gr. i
Mitte 100

15.

R

Scopolamine H.Br. 9.5%
Ophthalmic solution 15 c. c.

A summary of certain aspects of these small
samples is revealing:

Number of Prescriptions

Year	Containing Galenicals	Requiring Compounding	Containing Trade name drugs	Containing drugs not available previous date
1904	11	12	1	-
1930	5	10	5	4
1945	1	3	7	7
1960	0	1	15	11

The percentage of Galenicals in 1904 is rather revealing. We prepared this brief of two pages for the years 1945 to 1960, and the number of years before, and we have a summary of this which is revealing. Those which contained galenicals in 1904 were 11. - those are plant drug samples - in 1960, there were none. Those requiring compounding in 1904 were 12 and that has been reduced to 1 in 1960. Those which contained trade name drugs had only 1 in 1904, and there



1 are 15 in 1960. Those which contained drugs not
2 available on the previous date were recorded as being
3 11 in 1960; containing drugs not available in 1945, 7,
4 and containing drugs not available in 1930, there were
5 only 4.

6 It should be remembered that each group of
7 prescriptions (15) is too small to present a statistically
8 accurate picture, but the general picture is unmistakably
9 clear in several respects:

10 (i) the use of traditional galenical-type
11 preparations has practically disappeared,
12 those almost gone as has been indicated -
13 indicating that such medication is not
14 nearly as effective as are modern drugs.

15 (ii) the emphasis on trade-name drugs is a re-
16 flection of the role which the pharmaceutical
17 industry has played in the development of
18 modern medication.

19 (iii) the very small percentage of prescriptions
20 which require compounding by the dispensing
21 pharmacist to-day indicates that a high
22 percentage of modern medication is complex
23 and difficult to produce without expensive
24 machinery and laboratory equipment.
25 Especially does the necessity for proper
26 quality control require of these medicines a
27 well-outfitted laboratory and adequate
28 scientific personnel.
29
30



(iv) the high percentage of prescriptions
(11 out of 15) - by the way, it is
higher when you take a larger number -
in 1960 which could not have been filled in
1945 indicates the rapidity of development of
new drugs; thus the rate of obsolescence
is high. This is a factor which has an
effect on costs of medication, yet when we
consider that superior drugs are the re-
placements, the health of the public as
reflected in shorter periods of illness
and greater longevity are worth-while
dividends. Research leading to the develop-
ment of new drugs and the improvement of
existing medication is carried out by
pharmaceutical manufacturers, by schools
of medicine, schools of pharmacy, and to
some extent in government laboratories and
research institutes.

That brings us down to pharmacy as it is to-day
in the drug picture today.

The scientific and technological advances in
respect to medicine between 1935 and 1950 required
substantial adjustments in pharmaceutical education. In
Ontario the programme of education required for qualifi-
cation was advanced from 3 years of apprenticeship and 2
years of college to 4 years of university and, in effect,
one year of internship after graduation. The graduate
in pharmacy to-day has received: a sound foundation in



1 the physical and biological sciences, some courses in
2 the social sciences and humanities, and professional
3 and applied scientific studies in pharmaceuticals,
4 pharmaceutical chemistry, pharmacognosy, that is plant
5 drugs and plant chemistry, and pharmacy administration.
6 Options in the fourth year of the course permit the
7 undergraduate to prepare for any one of the several
8 branches of pharmacy - retail, hospital, industrial,
9 analytical or for graduate study. In the University of
10 Toronto qualified candidates may undertake graduate
11 study including research leading to the degree, Master
12 of Science in Pharmacy - that is a step toward the
13 doctorate of philosophy, which is a qualification for
14 research posts in industry or teaching positions in
15 universities.

16 To-day, then, graduates in pharmacy find
17 employment in:
18 retail pharmacy
19 hospital pharmacy
20 government laboratories as pharmaceutical chemists (mainly
21 analytical)
22 drug inspectors
23 armed services - a variety of posts, commissioned officers
24 in Medical Corps to
25 teaching
26 in industrial pharmacy in a variety of positions in
27 research, in parts of laboratory control
28 production, medical detailing in particular.

29 In Canada today, the distribution of the total
30 of about 9100 pharmacists is approximately as follows:



1 There are about 8,000 pharmacists in retail
2 pharmacies. There are 5,000 retail pharmacies alto-
3 gether. Hospital pharmacy - 330.

4 In the government service, both the civil
5 service and the armed services, about 100.

6 In industrial pharmacy, roughly 600, and in
7 teaching about 63.

8 In Ontario, the distribution of the total of
9 about 3800 pharmacists is approximately: There are
10 3,300 pharmacists in retail pharmacies out of a total of
11 1,960 pharmacies. That is not the date. That is the
12 number of retail pharmacies. Hospitals and clinics -
13 120 in 86 hospital or clinic pharmacies; armed services
14 and civil service - 35, 300 in industry and 11 in
15 teaching.

16 The Pharmaceutical Industry

17 The manufacturing branch of pharmacy has
18 expanded greatly since 1935. In the United States the
19 value of pharmaceutical preparations produced increased
20 nearly five times between 1939 and 1954 while payroll
21 increased about eight times. (U.S. Census of Manufacturers,
22 1954). Comparative Canadian figures show increases of
23 4 and 5 times respectively (D.B.S.). The greater
24 increase in salaries and wages compared with value of
25 production reflects in part the increased proportion of
26 scientific personnel engaged in research to-day. It is
27 significant that in the United States in 1959 nearly
28 \$200,000,000 is reported as having been spent on research
29 by the pharmaceutical industry, that is equal to about
30



1 9 percent of sales. The average for all U.S. industry
2 is reported as 2 percent. About 20 percent of the
3 pharmaceutical industrial research is listed as basic
4 research.

5 That is not directed towards the production of
6 a product but for the discovery of a carefully laid out
7 basic ~~scientific~~ experiment.

8 Most Canadian companies, which are subsidiaries
9 of foreign companies do little or no research in Canada,
10 but there are several notable exceptions. Then we have
11 Canadian companies that do research. One large Canadian
12 company has reported that in 1934 it expended 3 percent
13 of its sales on research compared with 8.5 percent in
14 1959, when sales were a number of times greater than in
15 1934. Figures for two large U.S. companies with
16 Canadian branches show expenditures on research by the
17 parent company of the order of 20 times greater in 1959
18 compared with 1935 to 1937.

19 It will be of some interest to outline briefly
20 how new drugs are discovered, developed and marketed
21 to-day. I am only summarizing, Mr. Chairman. I am
22 not presenting intimate details of this. That can be
23 obtained from other sources. From the time a new
24 chemical has been synthesized in the laboratory many
25 months - even several years - may elapse before it can
26 be released for general use. It must first be screened
27 by tests on animals to determine whether or not it has a
28 type of pharmacological activity which shows possible
29 potential as a therapeutic agent. Many of those
30



1 synthesized do not pass these tests. Then it must be
2 tested on animals for toxicity and side reactions. Again
3 many fail to meet safety standards at this level.
4 Assuming it does, dosage is then carefully worked out,
5 suitable dosage forms are developed, being tested at
6 each stage for potency and stability. The product is
7 then put into production, at first on a small pilot
8 scale. Very thorough clinical trials must be conducted
9 by physicians who record carefully the effects on and
10 the response of the patients. Some do not pass these
11 tests. It has been estimated that to synthesize and
12 test a new chemical some 400 man-hours are required.
13 Finally, when the company is satisfied that the drug is
14 effective, safe and stable, in suitable dosage forms,
15 it must submit all its experimental and clinical evidence
16 to the Food and Drug Directorate at Ottawa which must be
17 satisfied before granting approval of its release for
18 sale in Canada.

19 Some figures will reveal the truth of what
20 someone recently said about drug research: "more often
21 failure is our most important product". Mr. Chairman,
22 I say thank you.
23
24
25
26
27
28
29
30



1 One laboratory in a search for a new antibiotic tested
2 organisms from over 12,000 soil samples over a five-
3 year period before one useful and safe one was found.
4 Soil is used because these organisms often produce
5 antibiotic subjects. Leading to discovery of one
6 antibiotic, it is reported that 55 scientists worked
7 nearly three years at a cost of \$4,000,000 screening
8 100,000 soil samples. A company reported at one stage
9 having expended over \$2,000,000 over four years with-
10 out having been successful. About a dozen "sulfa" drugs
11 have been found useful as anti-infectives. I just
12 picked that out of the air. It is about the number
13 used. Over 5000 have been tested and discarded. But
14 some of these "failures" have led to other types of
15 agents - Tolbutamide, oral anti-diabetic, and
16 Chlorothiazide, a potent diuretic useful in high
17 blood pressure. Following the discovery of cortisone,
18 some 20,000 different steroids are said to have been
19 synthesized with fewer than 40 of the 20,000, having
20 any apparent medical value.

21 Another consequence of modern drug develop-
22 ment is speedy obsolescence of even very good drugs
23 as modifications of structure or the discovery of
24 completely new ones make superior products available.
25 Each year there are between 300 and 400 new pres-
26 cription products introduced in the United States and
27 Canada. They are not all the same for the two
28 countries, but the total in each country is the same.
29 Some of these are new chemical substances, others are
30



1 duplications of existing products, some are new
2 dosage forms. In 1959, I think the number was 67 or
3 70 of new chemical substances; rather high. As
4 these new introductions find their place older, less
5 effective drugs decline in demand and a number each
6 year are withdrawn. Some companies, however, carry in
7 stock as a service to prescribers, quite a number of
8 preparations with such a low demand that they are
9 financial liabilities. The expense of this service
10 must be met, of course, by revenue from other
11 products.

12 The rapidity of the development was well
13 pointed up by Sir Henry Dale in 1957, addressing a
14 medical meeting in London, Eng.:

15 "It is hardly to be expected that pharmacopoeias,
16 "textbooks or even annually revised lectures
17 "will continue to keep pace with materia medica
18 "(i.e. medicinal agents) subject to continual
19 "innovation and replacement, depending, for
20 "source of supply and to a large and growing
21 "extent for the researches producing the new
22 "remedial agents, on large scale pharmaceutical
23 "industry."

24 What proportion of new drugs are the result
25 of research in the industry? This is a question no
26 one can answer positively because final discoveries so
27 often depend upon a number of small, often insigni-
28 ficant discoveries, sometimes only very indirectly
29 related to the ultimate one. For instance, a thesis
30



1 for a master's degree perhaps in biochemistry may
2 contribute to the knowledge of a tissue enzyme. This
3 may be the last link in a chain of knowledge which
4 gives another laboratory the final answer to the precise
5 type of chemical structure required for a particular
6 drug action. A number of companies, especially in
7 the United States, substantially support basic
8 research in university schools of pharmacy and in
9 medicine, in part with this purpose in view. As to how
10 many discoveries actually emanate from the companies'
11 laboratories, I do know they are substantial and
12 increasing. As was recently pointed out by a medical
13 authority, every antibiotic since the first two,
14 penicillin and streptomycin, came from industrial
15 pharmaceutical research laboratories. I made a note
16 in my copy, Mr. Chairman, to suggest that elaboration
17 of this specific point might well be sought from the
18 industry.

19
20 Products are introduced to prescribers and
21 pharmacists by medical service representatives, by
22 advertising in professional journals, and by direct
23 mail advertising, as well as certain other journals.
24 It has been contended by some that the industry is
25 wasteful in this respect and that the cost of medica-
26 tion is increased accordingly. The industry itself can
27 answer this with more exact figures than I would
28 attempt to give you. For some years of experience and
29 observation, however, I believe, I firmly believe
30 this to be true, that the promotion employed serves two



1 useful purposes as far as the public is concerned:

- 2 (a) it actually reduces costs because of the greater
3 volume of the drugs used provided always that they
4 are competitively equal to or better than others, and
5 (b) it serves the important function of providing
6 information about the latest products of research to
7 prescriber and dispenser alike.

8 Retail and Hospital Pharmacy

9 These are the two branches of Pharmacy where
10 the actual contact with the public occurs. Here it
11 is that the products of research, both current and
12 of years past, are carefully selected, checked, com-
13 pounded if necessary, and supplied in accordance with
14 the prescriber's request. I would emphasize, Mr.
15 Chairman, that the degree of knowledge required --
16 both scientific and professional -- is as great in these
17 positions as in any of the other branches of pharmacy.

18 "Pharmacy" has been defined as the applica-
19 tion of the sciences of chemistry, physics and
20 biology to the preparation and control of medicinal
21 substances. Basically, the pharmacist -- in whatever
22 branch he serves -- is a specialist in the science of
23 drugs. He must understand their composition,
24 chemical properties, manufacture, and uses, and how to
25 test them for purity and strength. In this capacity
26 the hospital or retail pharmacist stands as a guardian
27 of the health of his community whether he practises in
28 a hospital or in a small or large retail pharmacy, a
29 corner shop, a strictly prescription pharmacy, or a
30



1 large shopping centre unit. In any case the heart of
2 his establishment is the dispensary together with the
3 drug and sick-room supplies section. Not only must
4 he have an expert knowledge of the multitude of
5 prescription and other drugs, but he must be able to
6 exercise the technical and manipulative skills required
7 in preparing, preserving, compounding and dispensing
8 drugs. He must exercise mature judgment in dealing
9 with confidential matters involving the patient and
10 the physician, as well as in dealing directly with
11 the public in the sale of drugs.

12 I have introduced this section in this way
13 because all too often those outside the health pro-
14 fessions are inclined to regard the modern practice of
15 retail pharmacy as (a) largely a business operation,
16 and (b) not requiring the compounding skill of the
17 apothecary of a few decades ago. Let me deal in turn
18 with each of these.

19 The North American retail pharmacy -- or drug
20 store as it was mainly called for many years -- for a
21 variety of reasons developed as a combination of the
22 European apothecary shop (operated by a professionally
23 educated and qualified pharmacist) and European drug
24 store (operated by a person without such qualification).
25 In the latter, only certain types of medicines could be
26 sold, e.g., similar to "patent medicines" in Canada. In
27 Ontario we have witnessed in the past several generations
28 two trends. On the one hand there has been an increase in the
29 number of strictly professional pharmacies. At the same time
30 there is now a trend to the large, well-lighted, well



1 appointed shop where there are generally excellent
2 professional departments, but also a great variety of
3 unrelated materials. In these establishments staffs are
4 large and include both professional and non-professional
5 personnel. The latter take care as much as possible
6 of the non-pharmaceutical commodities. But, in these
7 pharmacies as in all others, the pharmacist has the same
8 qualifications and serves the same function, as is his
9 responsibility under the Pharmacy Act of this Province.
10 It may seem paradoxical that there should be these two
11 opposite trends, but I think both will continue. There
12 will be, I believe, larger pharmacies employing larger
13 numbers of both professional and non-professional persons,
14 and at the same time more strictly professional
15 pharmacies with professional staffs.

16 In whatever type of pharmacy the modern
17 pharmacist serves, either as owner, manager or staff
18 pharmacist, he remains the custodian of poisons and
19 the specialist in the science of drugs. While modern
20 prescriptions do not require the exercise of the ancient
21 art of the apothecary in compounding as frequently as
22 formerly, they do demand much more of scientific
23 knowledge respecting the medicines prescribed. It is
24 probably not widely known that the pharmacist is
25 responsible for the quality and the integrity of the
26 drugs which he dispenses on prescription. He is also
27 responsible if an overdose is prescribed and he dispenses
28 it, should any harm ensue. His training is such, then,
29 that by law he is expected to protect equally the
30



1 physician and the patient. Doctors are human and make
2 mistakes. Sometimes, too, by inadvertence a wrong dose
3 may be written on a prescription. Over years of
4 practice every pharmacist accumulates a series of such
5 which he had observed and corrected after consultation
6 with the prescriber.

7
8 There is also the problem posed today by the
9 thousands of brand names, some of them very similar to
10 others, and hundreds of complex chemical names and
11 shorter but often difficult generic names. I am going
12 to give some examples in a moment. To make this more
13 difficult there is the regular turnover through
14 obsolescence, then withdrawal, of older drugs, and
15 the introduction of new drugs and new names. One of my
16 responsibilities is to supply five professional journals
17 (3 medical, 1 pharmaceutical, 1 nursing) with descrip-
18 tions of new drug products each month. Each year
19 as the several hundred new introductions pile up I
20 never cease to marvel at the dispensing pharmacist who
21 must keep these names sorted out. The physician only
22 has to remember the particular ones he is interested in
23 prescribing, but the pharmacist must be able to identify
24 and to answer all sorts of questions about any one of
25 several thousand, and not the same several thousand
26 each year. In Canada alone there are in the neigh-
27 bourhood of 5,000 named, dispensed pharmaceutical
28 products.

29 In view of this heavy professional responsibility
30 and the basic scientific knowledge which must be used



1 regularly, I find it difficult to understand why some
2 seem to regard the dispensing of a prescription which
3 might call for a dozen tablets, or a tube of oint-
4 ment, or a bottle of prepared medicine, as simply a
5 commercial sale and requiring nothing more than the
6 ability to read labels. Some even suggest that a pro-
7 fessional fee should not be charged for this service.
8 When I think of the errors which could happen so often
9 if the dispenser did not have the knowledge he does
10 possess, I wonder why some criticisms which have been
11 spoken and printed can be made, unless it is through
12 lack of knowledge of these facts.

13
14 As an example of confusion which could
15 easily arise through similar names, we have included
16 in this summary several pairs which speak for them-
17 selves. These are all from recent Canadian listings.
18 PAS -- para-amino salicylic acid (or one of its
19 salts), anti-tubercular agent. P.A.S. -- a phosphorus,
20 arsenic and strychnine "tonic" substance. One of them
21 a potent chemical used as an anti-tubercular agent.
22 Preludin -- an appetite-depressant drug, used in the
23 management of obesity. Proluton -- an oral hormone
24 product used in various female reproductive dis-
25 turbances. Tensilone and Tensilon, the only difference
26 an "e" on the end of one. Tensilone -- a nitroglycerin
27 and diuretic formula for use in high blood pressure.
28 Tensilon -- a powerful antagonist of curare, which
29 itself is a very potent muscle relaxant. Demerol --
30 a potent pain-relieving narcotic drug.



1 Dermiol -- an ointment. Diagen -- a barbiturate
2 sedative and hypnotic. Diagnex Blue -- a diagnostic
3 agent in cancer of the stomach, pernicious anaemia, etc.
4 Following is a series of steps which a pharmacist must
5 take when he fills a prescription: I should have
6 reported this is taken verbatim from Facts about
7 Pharmacy and Pharmaceuticals, the Health News Institute
8 Publication. These are the steps, I won't read them
9 all. I will just read a few and show you how time-
10 consuming and how tedious it could be and what care
11 must be exercised.

- 12 1. Make sure that he can decipher the hand-
13 writing unmistakably. That is not always easy.
 - 14 2. Determine that the dosage specified is
15 correct for the patient's age.
 - 16 3. Decide what quantities he will need for
17 each of the ingredients in the prescription.
 - 18 4. Assemble all the ingredients needed and line
19 them up on the prescription desk.
 - 20 5. Fill the prescription in the manner best
21 calculated to yield the product that the physician
22 wants.
- 23
24
25 -
26
27
28 -
29
30 -



1 Maybe it is a brown glass bottle; maybe it must be
2 completely filled, must be air-tight, must have
3 directions, "keep on ice", and so on.

4 7. Type the doctor's directions on a prescription
5 label and affix the label to the container. Add to the
6 label a serial number which will facilitate the locating
7 of the original prescription should it be required at
8 some future time.

9 8. Calculate the price of the prescription.

10 9. Enter the prescription, with its serial number
11 in a record book. Include in the record the name of the
12 doctor, the name and address of the patient, the
13 initials of the pharmacist who filled the prescription,
14 the physical form of the prescription, and the price.

15 That goes down to 14. I wonder if any of
16 you who are professionally engaged in some practice were
17 asked to put that fee simply for the professional
18 services rendered, how much it would be.

19 10. Enter on the prescription itself the serial
20 number, the date the prescription was filled, the price,
21 and the initials of the pharmacist who worked on it.

22 11. Double check the entire process. An error in
23 filling a prescription can result in grave consequences.

24 12. Return the prescription ingredients to their
25 proper places on the shelf. This in itself constitutes
26 another checkup procedure.

27 13. File the original prescription so that it can
28 be found quickly when needed.

29 14. Hand the finished product to the customer,
30



1 mentioning any instructions made necessary for the nature
2 of the preparation. For example: "Be sure to keep this
3 in your refrigerator."

4 The following statement made by the President
5 of the American Medical Association in 1959 underscores
6 my point:

7 "During these years of drug progress, the
8 pharmacist will continue to be faced with professional
9 emphasis on knowledge, integrity, judgment,
10 honesty, dependability, vested authority and
11 accepted responsibility. These prerequisites of a
12 profession are placed daily at the disposal of the
13 general public for their protection.
14 More and more, the public service role of the
15 pharmacist is depending not so much on what he does
16 as upon what he knows."

17 A good reflection both of the problem of names -
18 chemical, generic or brand - and also the great increase
19 in extremely potent synthetic medication is seen in a
20 comparison of the narcotic drugs in the Schedule to the
21 Opium and Narcotic Drug Act 1927 and 1952 (amendments to
22 1959). These are drugs which may be dispensed by the
23 pharmacist under very careful and precise conditions. He
24 is required to keep an accurate record of every purchase
25 and sale for examination at any time by an inspector.

26 I am not going to read these. There are a
27 couple of pages of them. You will notice that there are
28 six listings in 1959, and we recorded about half of
29 them. I do not know how many listings there are, there
30



1 must be seventy-five or eighty, but look at their
2 names.

3 Turn to page 30 and under No. 4 you will see
4 listed the phenypiperidines, their preparations,
5 derivatives and salts, as for example, "Anopridine
6 (ethyl 1- 3-(phenylamino)propyl -4-phenylpiperidine-4-
7 carboxylate)." That is just one. There are fourteen
8 in that one group alone. That indicates how the
9 synthetic laboratories have taken over modern medication.
10 The pharmacists has to know the names and understand
11 the meanings.

12 1927

13 "Cocaine or any salts or compounds thereof.

14 Morphine or any salts or compounds thereof, but not
15 including apomorphine.

16 Heroin or any salts or compounds thereof.

17 Opium or its preparations, or any opium alkaloids, or
18 their derivatives, or salts or preparations of opium
19 alkaloids or their derivatives, but not including codeine
20 or apomorphine.

21 Eucaïne or any salts or compounds thereof.

22 Cannabis Indica (Indian Hemp) or Hasheesh, or its
23 preparations or compounds or derivatives, or their
24 preparations and compounds. 1923, c. 22, Sch.; 1925,
25 c. 20, s. 11."

26 1959

27 "1. Opium Poppy (Papaver somniferum) its preparations,
28 derivatives, alkaloids and salts, as for example:

29 (1) Opium,
30



(2) Codiene (methyilmorphine),

(3) Morphine,

(4) Narcotine,

(5) Papaverine,

(6) Thebaine,

and their preparations, derivatives and salts, as for
example:

(7) Acetyldihydrocodeine,

(8) Benzylmorphine,

(9) Desomorphine (dihydrodeoxymorphine),

(10) Diacetylmorphine (heroin),

(11) Dihydrocodeine,

(12) Dihydromorphine,

(13) Ethylmorphine,

(14) Hydrocodone (dihydrocodeinone),

(15) Hydromorphone (dihydromorphinone)

(16) Methyldesorphine (/ -deoxy-6-methyilmorphine),

(17) Methyldihydromorphine (dihydro-6-methyilmorphine),

(18) Metopon (dihydromethylmorphinone),

(19) Morphine-N-oxide (morphine N-oxide),

(20) Myrophine (benzylmorphine myristate),

(21) Nalorphine (N-allylnormorphine),

(22) Nicomorphine (dinicotinyilmorphine),

(23) Normorphine,

(24) Oxycodone (dihydrohydroxycodeinone),

(25) Oxymorphone (dihydrohydroxymorphinone),

(26) Pholcodine (B-4-morpholinoethylmorphine), and

(27) Thebacon (acetyldihydrocodeinone),

but not including:

(28) Apomorphine, and



"2. Coca (Erythroxyton), its preparations, derivatives, alkaloids and salts, as for example: (1) Coca leaves, (2) Cocaine, and (3) Ecgonine (3-hydroxy-2-tropane carboxylic acid).

"3. Cannabis sativa, its preparations, derivatives and similar synthetic preparations, as for example:

(1) Cannabis resin, (2) Cannabis (marihuana), (3) Cannabinol (3-n-amy1-6, 6,9-trimethyl-6-dibenzopyran-1-ol), and (4) Pyrahexyl (3-n-hexyl-6, 6,9-trimethyl-7,8,9,10-tetrahydro-6-dibenzopyran-1-ol).

"4. Phenypiperidines, their preparations, derivatives and salts, as for example: (1) Alperidine (3-allyl-1-methyl-4-phenyl-4-piperidyl propionate), (2) Alphameprodine (4-3-ethyl-1-methyl-4-phenyl-4-piperidyl propionate), (4) Anileridine (ethyl 1-[2-(p-aminophenyl) ethyl]-4-phenylpiperidine-4-carboxylate).

(5) "Anopridine (ethyl 1-[3-(phenylamino)propyl]-4-phenylpiperidine-4-carboxylate)," (6) Betameprodine (B-3-ethyl-1-methyl-4-piperidyl propionate), (7) Betaprodine (B-1,3-dimethyl-4-phenyl-4-piperidyl propionate), (8) Etoxeridine (ethyl 1-[2-(2-hydroxyethoxy)ethyl]-4-phenylpiperidine-4-carboxylate), (9) Hydroxypethidine (ethyl 4-(m-hydroxyphenyl)-1-methyl-4-phenylpiperidine-4-carboxylate),

(10) Ketobemidone (1-[4-(m-hydroxyphenyl)-1-methyl-4-piperidyl]-1-propanone),

(11) Morpheridine (ethyl 1-(2-morpholinoethyl)-4-phenylpiperidine-4-carboxylate),

(12) Pethidine (ethyl 1-methyl-4-phenylpiperidine-4-carboxylate),



(13) Properidine (isopropyl 1-methyl-4-phenylpiperidine-4-carboxylate, and

(14) Trimeperidine (1,2,5-trimethyl-4-phenyl-4-piperidyl propionate).

"5. Phenazepines, their preparations, derivatives and salts, as for example:

(1) Proheptazine (hexahydro-1, 3-dimethyl-4-phenyl-4-azepinyl propionate), but not including:

(2) Ethoheptazine (ethyl hexahydro-1-methyl-4-phenyl-4-azepinecarboxylate)."



1 This is just over one-half of the list.

2 A similar comparison of the schedules of the Food
3 and Drug Act, listing those drugs which may only be
4 supplied upon the prescription of an authorized practitioner
5 is revealing. The first such schedules in 1941 listed
6 15 names, the last as amended in 1960 included some 118
7 names. Actually in both cases, especially the later
8 group, the number of drugs included is much larger as
9 some entries read as:

10 "Barbituric Acid its salts and derivatives".

11 There may be fifty of those alone.

12 Details of these are readily available if they are
13 of interest to the Committee. I see you all have a
14 copy of the Act on your desks.

15 Special Problems of the Hospital Pharmacist

16 As the specific terms of reference for your
17 study concerns primarily drugs in hospitals and other
18 institutions, one would anticipate that you will seek
19 testimony from one or more pharmacists in such institutions.
20 Most certainly they can supply you with information with
21 which I may be only slightly familiar. For completeness,
22 however, at least in respect to topics, I shall outline
23 briefly some of the main responsibilities of pharmacists
24 (chief pharmacist and staff pharmacists) employed in
25 hospitals. These may be enumerated as follows:

- 26 1. To compound and dispense prescriptions for
27 in-patients and, if there is an outpatient department,
28 also for outpatients.
29 2. To keep the wards supplied with stock medication
30



1 for use as ordered on the respective floors and wards by
2 physicians.

3 3. To purchase all drugs required as economically
4 as possible consistent with the medication ordered by
5 the prescribers in the hospital and always in accordance
6 with quality.

7 4. In some hospitals, some manufacturing is done
8 in the pharmacy.

9 5. In a few hospitals, the pharmacists are
10 responsible for the sterile supply room, i.e.
11 intravenous solutions, etc.

12 6. Giving lectures to student nurses.

13 7. Serving on the Pharmacy and Therapeutics Committee
14 where such exists. This Committee is concerned with
15 medication to be used in the hospital and in many cases,
16 the compilation of a formulary. Responsibility for
17 compiling the latter is largely the pharmacists'. His
18 thorough knowledge of the constantly changing picture in
19 available medication is invaluable for this purpose.

20 Apart from the routine functions there are not
21 infrequently consultative services, both formal and
22 informal, sought by physicians and nurses. I know one
23 hospital pharmacist who was able to enumerate 62 recent
24 such instances. Many of these involved dosages of newer
25 medication or confusion of names of products. It is
26 common to have enquiries regarding new drugs which are
27 just undergoing clinical trial and are not yet on the
28 market. A good library of product reference books is
29 essential in to-day's pharmacy.
30



1 It is somewhat of a paradox that hospitals
2 are not required by law to have a pharmacist in charge
3 of the pharmacy. The Pharmacy Act specifically exempts
4 such institutions. When this exemption was written
5 into the Act I am quite sure that the legislators could
6 not foresee the development of a complex, changing,
7 exceedingly potent materia medica such as we have to-day.
8 Therefore, despite the legal requirement to do so, I
9 believe that most administrators of hospitals over 50
10 beds now either have on staff one or more full-time
11 pharmacists or, in some cases of the smaller institutions,
12 arrange for pharmaceutical services to be supplied by a
13 local retail pharmacist.

14 Summary

15 In arranging this presentation, Mr. Chairman,
16 I have made no attempt to deal exhaustively with any one
17 of the topics included. In the interest of economy of
18 time this seemed to be preferable. Perhaps you would
19 have wished more detail about some aspects of this
20 submission. If so, I am quite willing to return to
21 another sitting for any such purpose which you may
22 designate.

23 It would seem desirable that you should have
24 more detailed expert testimony concerning several aspects
25 in particular. I would suggest, therefore, that you
26 will wish to invite expert witnesses for information on
27 such topics as: Hospital Pharmacy; The Canadian
28 pharmaceutical industry; Retail pharmacy and pharmaceutical
29 economics.
30



1 In summarizing briefly I would point out,
2 first, that to-day we are dealing mainly with totally
3 different types of drugs than were known just three or
4 four decades ago. There is no comparison, whatever,
5 in their relative merits as demonstrated by the longer
6 life span to-day, and reduced death rates from many
7 diseases, especially infections. Nor is there any
8 comparison in the relative costs of developing them.
9 The discovery of sulphanilamide inaugurated an era of
10 intensified research for new synthetic drugs and
11 antibiotics as well as drugs from natural sources. The
12 ensuing changes have altered greatly the complexion of
13 and the education for the practice of pharmacy. The
14 pharmaceutical industry, which has developed tremendously,
15 has played and is playing an increasingly important role
16 in the research for new and even better drugs.

17 Because of the costs of research, development
18 and quality control at the industrial level, and
19 substantially higher costs of operation, including
20 inventories of three or more times those of a few years
21 ago at the retail level, it would seem anachronistic to
22 apply the same type of measure to-day as would have been
23 suitable a few years ago. Especially is this so,
24 having regard to the superior quality - in terms of
25 results - of to-day's drugs.

26 Attached hereto are appendixes with certain
27 statistical information which turned up in the
28 collection of material for this submission. Perhaps
29 members of the Committee may find them helpful.
30



1 I won't go over these except to mention one
2 or two of the appendices in particular.

3 Appendix 1, lists the average charge for
4 prescriptions in retail pharmacies in Ontario, Canada
5 and the United States in the years 1951 to 1958.
6 These are taken from the sources indicated.

7 I should perhaps warn the Committee of this
8 fact, that statistics of this type cannot be taken as
9 one hundred percent accurate, wherever you take them,
10 because, I imagine, that from one survey they will
11 show one thing, and in another survey, they will show
12 something different. There are differences in
13 localities and the waiting between surveys accounts for
14 the difference, but these are reasonably close to each
15 other.

16 Appendix 2, lists some of the results of
17 the newer drugs.

18 Appendix 3, is a very important one in this
19 respect, it shows the ratio of drug costs to total expenses
20 of hospital operations. In one particular hospital,
21 a large one in Toronto, St. Michael's. It shows that
22 the medicine and drugs constitute rather a small part
23 of the total cost of operating a hospital.

24 Appendix 4 shows the number of scientists per
25 thousand employers in the top four "research minded"
26 industries in the United States.

27 Appendix 5 shows where they take the cost of
28 drugs per capita consumption, and we are dealing with
29 only a very small proportion of the total expenses incurred
30



1 by the family or individual.

2 Appendix I

3 Average Charge for Prescriptions in Retail Pharmacy

4 <u>Year</u>	Ontario*	Canada*	U.S.A.#
5 1951	not avail.	\$1.68	\$1.90
6 1952	\$1.76	1.82	2.08
7 1953	2.07	2.07	2.19
8 1954	2.19	2.28	2.27
9 1955	2.38	2.26	2.46
10 1956	2.61	2.49	2.62
11 1957	2.69	2.61	2.85
12 1958	2.97	2.78	2.98

13 *from Canadian Pharmaceutical Association Annual Survey
14 of Canadian Retail Pharmacies, Professor H. J.
15 Fuller.

16 #from Eli Lilly Co. Annual Digest of Retail Pharmacy.

18 Appendix II

19 Some figures from various sources respecting
20 mortality and morbidity rates (U.S. figures)

21 Tuberculosis death rate: in 1929 - 80; in 1959 - 6.
22 (per 100,000)

23 Whooping cough - 700 children died in 1949;
24 310 children died in 1959.

25 Deaths from 8 infectious diseases (pneumonia, meningococcal
26 infections, syphilis, whooping cough, scarlet
27 fever, diphtheria, tuberculosis, dysentery) were
28 reduced an average of 58% from 1945 to 1956.

29 Mortality rate in U.S.A. declined over 30% in last 25 years.
30



Appendix III

The ratio of drug costs to total expenses of hospital operations appears small. Following is 1959 statement of expenses of St. Michael's Hospital, Toronto, broken down into percentages:

Salaries and wages - 66.2%
Medical and surgical supplies - 3.32%
Medicines and drugs - 4.48%
Other supplies and expenses - 19.2%
Depreciation - 6.8%

Appendix IV

Number of scientists per 1,000 employers in the top four "research minded" industries in the United States:

Pharmaceutical - 4.50
Chemical - 1.27
Petroleum - 0.62
Electrical - 0.43.

Appendix V

Some statistics gathered from D.B.S. regarding family & personal expenses

1. Comparative per capita expenditures by Canadians 1958:

Alcohol - \$55.00
Tobacco - \$34.00
Prescription drugs - \$7.48

2. The average family spends more on automobile maintenance than is spent for drugs by 33 families.



Conclusion

In conclusion, Mr. Chairman, it seems to me that the people of this Province and this country are fortunate in the existence of the profession of pharmacy in all its branches, with its progressive outlook and sound educational foundation. As you pursue this investigation I would express the hope that you will bear in mind that the men and women which it represents are striving, in the main, as earnestly as they can with what resources they possess to meet in full their responsibilities to the people. They are dealing in goods and services which are unpopular in the sense that no one wants to have to buy them. This, I am sure, is the basic reason for public statements and public enquiries which in turn have prompted this investigation. As I view the entire field of pharmacy including the pharmaceutical industry I am certain its members welcome this opportunity to lay before this Select Committee and the public the complete picture of the cost of modern drugs. If you provide them with this opportunity and the complete picture is presented to the public, the many misconceptions which have arisen will be removed. This is important if our citizens are to regain the confidence and trust which modern medication and the profession of pharmacy richly deserve.

MR. CHAIRMAN: For the time being, sir, thank you for this very thorough presentation. I may assure you that we will probably be calling on your good offices for further assistance as the inquiry goes on.



1 MR. HUGHES: Thank you.

2 THE CHAIRMAN: Thank you, sir. We will
3 adjourn until 2 o'clock.
4

5 --- ADJOURNMENT UNTIL 2 O'CLOCK.
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1 ---On resuming at 2.00 p.m.

2
3 THE CHAIRMAN: Gentlemen, if you are
4 ready we will resume. The next statement or brief
5 is from the Ontario Department of Health, Dr. Gunn.

6 DR. DONALD R. GUNN (Director of Clinical
7 Research, Ontario Hospital, New Toronto): Mr. Chairman
8 and Members of the Select Committee: This brief
9 reviews the general principles which apply to the use
10 of drugs in mental hospitals in Ontario. It outlines
11 the various factors which may influence a physician's
12 selection of the drug to be administered and it dis-
13 cusses briefly the various types of drugs used in
14 the treatment of the mentally ill and the great increase
15 in the number of such preparations in recent years.

16 When mental hospitals, or lunatic asylums as
17 they were then known, were first opened in Ontario, the
18 knowledge of mental disorders had advanced little from
19 that of the middle ages. What little treatment there
20 was used, was based more on superstition and folk lore
21 than on sound medical knowledge. Until the present
22 century, most mental hospitals offered little more than
23 custodial care. It is true that the more enlightened
24 psychiatrists realized that their patients were sick
25 and sought to assist their recovery through the use
26 of sedatives, laxatives and such other medicines as
27 seemed appropriate.

28 The mental hospital of today is in every
29 sense a "hospital" and the mental hospital patient
30 receives not only psychiatric treatment but skilled



1 medical and surgical care as well. It has long been
2 recognized that a disease process is seldom limited to
3 one portion of the body or to a single organ or system.
4 The human body is an extremely complex mechanism in
5 which all parts are closely interrelated. Every part
6 of the body is dependant upon the integrity and health
7 of every other part, if it is to function normally.
8 Any abnormality or disease involving one organ or system
9 will almost inevitably have some degree of adverse
10 effect on all other organs or systems in the body.
11 Thus high blood pressure which is essentially a disease
12 of the heart and blood vessels (the cardio-vascular
13 system) may actually be due to a disorder of the brain
14 (the central nervous system) or the kidneys (the
15 excretory system). This condition may, on the other
16 hand, result in serious damage to these systems. Hence
17 many patients are admitted to mental hospital because
18 of mental symptoms directly attributable to high
19 blood pressure and hardening of the arteries. On the
20 other hand, one must be careful not to generalize that
21 all persons with high blood pressure and hardening of
22 the arteries will become mentally ill. The problem
23 is not nearly so simple and this only serves to
24 illustrate the great complexity of the human body
25 and the ills that may beset it.

26
27 In an Ontario Hospital there is a full-time
28 medical staff comprised of salaried physicians. The
29 senior staff members are specialists in psychiatry,
30 certified as such by the Royal College of Physicians



1 and Surgeons of Canada. The majority of the remaining
2 members of the staff are physicians undergoing post-
3 graduate training to become qualified for specialist
4 status. In addition to the full-time staff, each
5 mental hospital has a consultant staff consisting of
6 specialists in other branches of medicine such as
7 surgery, ophthalmology, disease of the eyes, otolaryngo-
8 logy, ear, nose and throat, dermatology, skin disease,
9 etc. The members of the consulting staff advise
10 concerning problems which arise within their specialty
11 and when necessary they carry out or direct such
12 treatment as may be required. The mental hospital
13 patient is thus assured of the best possible care and
14 treatment regardless of the nature of the illness with
15 which he is admitted, and also in the event of any
16 serious intercurrent illness which may develop while
17 he is in hospital.

18 The number of cases of serious physical illness
19 in a mental hospital at any one time is, of course,
20 much smaller than in a general hospital where the only
21 reason for admission is actual or suspected physical
22 illness. Nevertheless, the mental hospital staff may
23 be required, from time to time, to diagnose and treat
24 almost any kind of illness that is diagnosed and treated
25 in a general hospital. Hence all but the most elaborate
26 and expensive diagnostic aids and treatment facilities
27 of a modern general hospital are also available in the
28 Ontario Hospitals. In addition, most Ontario
29 Hospitals have many highly specialized facilities not
30



1 ordinarily available in a general hospital.

2 It should, perhaps, be noted in order to
3 complete the picture, that there is provision in the
4 Mental Hospitals Act for the transfer of a mentally
5 ill patient to a general hospital when it is in the
6 best interests of the patient to do so. Thus it is
7 possible to provide for the mental patient highly
8 specialized and often costly medical or surgical care
9 which it is not economically sound to provide in a
10 mental hospital.

11 DRUGS:

12 It is one of the cardinal principles of the
13 practice of medicine that a physician shall have free-
14 dom to treat his patient according to his own judgment,
15 training, experience, and skill. In the mental
16 hospital, then, he must be permitted to prescribe the
17 drugs that he believes to be indicated or effective
18 for the particular illness and for the particular
19 patient that he is treating. Always there is the
20 consideration that the physician is required by his
21 superintendent, if not by law, to use reasonable pro-
22 fessional skill at all times and to prescribe and use
23 only those drugs that he is qualified and competent
24 to use and which are considered to be safe and proper
25 under the circumstances of their use.

26 A patient, whether mentally ill or physically
27 ill, is a human being -- a person. People vary greatly
28 in their physical as well as their mental make-up,
29 and they differ in the way that they respond to
30 various drugs. A medicine, for example penicillin.



1 may be life saving when administered to one patient,
2 yet may cause a fatal reaction when given to another.
3 It is the responsibility of the doctor to know and
4 recognize these possibilities. He may, therefore,
5 use any one of several possible medications
6 appropriate for the illness from which his patient is
7 suffering. His choice will depend on his personal
8 knowledge of this patient as well as his knowledge and
9 experience with the various drugs at his disposal.

10 The practice of medicine is far from being a
11 precise science wherein it is possible to establish
12 infallibly a diagnosis and follow logically with a
13 specific form of treatment which will lead inevitably to
14 a cure. As already mentioned, patients are individuals.
15 So are physicians. Hence, the human element is of
16 tremendous, and in fact, almost of paramount importance
17 in the practice of medicine. The successful practi-
18 tioner must have confidence in himself and in his
19 treatment methods. The former he will gain from
20 his training, his teachers, and his experiences. The
21 latter can only come from a thorough knowledge of all
22 aspects of the drugs and techniques that he uses. It
23 may thus occur that a physician who administers a drug
24 of only moderate efficacy with great skill may have
25 much greater success in the treatment of a certain
26 illness than will another doctor who uses a more
27 potent or effective drug, but who lacks the knowledge
28 to use it to full advantage. Furthermore, a doctor
29 who prescribes a medication with which he is thoroughly
30



1 familiar often conveys in some subtle manner a sense
2 of confidence and of comfort to his patient which may
3 be almost as valuable as the medicine itself.

4 Many of the drugs used today have been known
5 and used for centuries. Some are relatively simple
6 compounds which occur naturally. Others are herbs
7 or herbal extracts such as cascara. The method of
8 manufacture or preparation is frequently simple and
9 well known, so that drugs of this kind are usually
10 made by a great many drug firms all over the world.
11 Often there is little or no difference whatever in the
12 products of the various manufacturers and governmental
13 controls ensure that they all meet the required standards
14 of purity and potency. There may, however, be subtle
15 differences in colour, consistency, flavour, or
16 presentation -- that is, whether in pills, capsules,
17 liquid, etc., which may greatly influence a physician's
18 preference for the product of one manufacturer over that
19 of the others. Three doctors might easily express
20 a preference for three different brands of the same
21 drug and each might have what is, in his opinion, a
22 very valid reason for his choice. If each doctor were
23 to insist on the brand of his choice, a hospital might
24 quite properly purchase and keep available all three
25 brands of the drug.

26 As a medical student and later as an interne,
27 the physician learns much about the use of drugs from
28 his teachers, clinicians and colleagues.
29
30



1 He finds that different teachers may advocate different
2 drugs for the treatment of the same or similar con-
3 ditions, their preferences depending upon personal
4 experience, knowledge of a particular drug, and
5 occasionally nothing more than prejudice. The young
6 physician, naturally enough, tends to follow the
7 example of his teachers and to prescribe the same
8 drugs, and gradually introduce new ones into his own
9 practice as he gains knowledge and new drugs become
10 available.

11 Even though the medical schools may en-
12 deavour to instill into their students a doctrine of
13 scientific objectivity, caution and breadth of
14 vision, doctors are still human beings. As they
15 engage in practice, their individual interests and
16 tendencies become manifest and they develop their
17 preferences and, inevitably, prejudices as well.

18 Within any one hospital, the number of
19 full-time and consulting staff will have a direct
20 bearing on the number of drugs used in the
21 hospital. The more skilled and the more experienced
22 these physicians become, the more carefully they are
23 apt to select the drugs they use. Many drugs have been
24 developed and introduced which have highly selective
25 action and which have an application limited largely,
26 if not exclusively, to specialized practice. Thus
27 each specialist consultant may require a number of drugs
28 to be available which are unlikely to be used by any
29 other member of the staff, yet all of these may be
30



1 quite essential to the adequate care of the patients in
2 the hospital.

3 The mental hospital of today is required to
4 cope with almost any kind of medical problem -- physical
5 as well as mental. The drugs used in a mental hospital
6 may, therefore, include a great many that are used in
7 general hospitals and others that are primarily of value
8 in the treatment of psychiatric disorders. Many drugs
9 are regularly and extensively used throughout the hos-
10 pital and are usually available at all times in the ward
11 medicine cabinets. Some less commonly used drugs are
12 carried as regular stock in the dispensary and issued
13 to the wards whenever necessary. A smaller number of
14 special preparations, such as those used for the treatment
15 of relatively uncommon conditions may be required to be
16 purchased in small quantities if and when actually needed.
17 This avoids the necessity for keeping many drugs unused
18 on the dispensary shelves for long periods at the risk
19 of deterioration or spoilage and consequent waste.

20 Many preparations are available which are in
21 effect prescriptions made up of a number of drugs and
22 made up as palatable liquids, suitably coloured tablets
23 or capsules, etc. These include cough mixtures, various
24 preparations for digestive disturbances, lotions,
25 liniments, and many other types of preparation. Each
26 hospital gradually develops a certain degree of
27 individuality in the medicines of this type that
28 are available from its dispensary. Some degree
29 of selection and control is commonly exercised by
30



1 the more senior staff members or by a pharmacy committee.
2 Nevertheless, if a particular mixture or compound is
3 desired by a specific staff member, it will almost
4 certainly be made available for his use.

5
6 In addition to what might be described as
7 "general drugs", that is, the large number of natural
8 and synthetic compounds, herbal extracts and drugs
9 derived from plant sources, there are a number of more
10 specialized groups of medicines regularly in use in
11 mental hospitals. One of the first and most important
12 of these groups is comprised of the sulpha drugs, or
13 sulphonamides as they are known collectively. Sulphani-
14 lamide, which was the first member of the family to come
15 into wide use, became available about 1936 or 1937 and
16 it was almost two years before the next of the sulpha
17 drugs came into use. Today, a great many of these com-
18 pounds are in regular use. Many more were introduced
19 during the intervening years only to be discarded as they
20 were replaced by others that were found to be more effec-
21 tive and safer to use. The sulphonamides were the first
22 of the so-called "wonder drugs" which were found to have
23 a specific direct effect on the causative organisms of
24 a number of diseases for which there had previously
25 been no really effective form of treatment. It was found,
26 however, that some micro-organisms tended to develop
27 resistance to these compounds. Furthermore, the
28 sulpha drugs frequently had serious side effects on
29 the patient, particularly on the kidneys. As newer
30 and more potent sulphonamides have been developed, they



1 have become more effective against the disease-producing
2 bacteria and safer for the patient. More recently some
3 members of this family of drugs have been found to have
4 an entirely different application. They have been found
5 to be effective in the treatment of some of the milder
6 cases of diabetes, and taken by mouth they effectively
7 replace insulin, which can only be given by hypodermic
8 injection.

9
10 Another important group is that of the
11 antibiotics. Of these, penicillin is the classical
12 example. These compounds are purified extracts of
13 highly potent chemical substances which are products of
14 the growth of various forms of moulds. The majority are
15 of identifiable chemical structure and some have recently
16 been prepared synthetically. Some forms of penicillin
17 are in this category. The antibiotics are somewhat
18 similar to the sulphonamides in that they are antibac-
19 terial agents, but they are much more highly specific and
20 selective in their action on bacteria. For the most
21 part they appear to interfere with the ability of
22 the bacteria to multiply normally, and they may also so
23 weaken the bacteria that these are readily overcome by
24 the patient's normal protective mechanisms. In some
25 instances the antibiotics may even actually destroy some
26 forms of bacteria. The antibiotics differ, one from
27 another, in their potency and in the specific organisms
28 against which they will give protection. Many bacteria
29 develop an extraordinary degree of resistance to certain
30 antibiotics while remaining susceptible to the action of



1 others. It is therefore necessary that several of these
2 agents be available in a hospital, and it is also
3 necessary that they be used with caution and skill, if
4 they are to remain useful and effective.

5 The vitamins are frequently of considerable
6 importance in the treatment of the mentally ill. It is
7 now well established that many patients who develop mental
8 disturbances as a result of protracted alcoholic epi-
9 sodes are suffering from a serious lack of certain
10 vitamins, particularly Vitamin B. Mentally ill persons
11 may, in the course of their illness, refuse to take
12 adequate nourishment or, because of their illness, may
13 have delusions about certain kinds of food. Whatever
14 their reasons, these patients may have quite faulty diets
15 for long periods before they finally come into hospital.
16 In such cases vitamin deficiencies are by no means
17 uncommon. Vitamins in many forms and combinations
18 are required for the treatment of such conditions, and
19 they are sometimes of great importance in aiding the
20 recovery of the patient. More often they are of
21 assistance in improving the general physical health of the
22 patient, which can be a factor in ultimate recovery.
23 Every psychiatrist is well aware that a sound body and
24 a sound mind go hand in hand.

25 Sedatives have a very much smaller application
26 in a mental hospital than is commonly supposed. Thirty
27 years ago, when we had few of our modern treatment methods,
28 sedatives were the only medications that we could use to
29 quieten a disturbed and excited patient, or to calm the
30



1 fears of the anxious and depressed patient. At that time
2 there were some fifteen or sixteen different sedatives
3 in use. Today more than three times that number is avail-
4 able, although some are of little value in a mental hospi-
5 tal. A number of the relatively mild new sedatives appear
6 to be useful in psychiatric out-patient practice and in
7 private practice. Within the mental hospital, however,
8 some of the more potent sedatives may find application.
9 In some instances they are of value during the period
10 immediately following admission, before other more speci-
11 fic forms of treatment have had time to become effective.
12 Sedatives are valuable in preparing a patient for such
13 procedures as electroshock treatments. Our present
14 treatment methods have become so effective that the vast
15 majority of patients in our mental hospitals, even those
16 who are still quite seriously mentally ill, are quiet and
17 co-operative. The patient who is too upset to be able
18 to sleep normally is becoming rare indeed. The use
19 of sedatives to aid patients to sleep at night, and to
20 keep noisy patients quiet, is becoming a thing of the
21 past.

22
23 Drugs used for the treatment of epilepsy are
24 known as antiepileptics or anticonvulsants. In 1934
25 there were only two drugs in this category, bromide and
26 phenobarbital. Diphenylhydantoin, the first of a whole
27 new series of antiepileptic drugs, was introduced
28 in 1938, and today some twenty or more antiepileptics
29 are known and in use. Bromide no longer has an applica-
30 tion in the treatment of epilepsy, while phenobarbital



1 is still used extensively. Several other drugs were
2 introduced in the intervening years, only to be
3 abandoned because of undesirable side effects.
4 Additional anticonvulsants may be expected to become
5 available as the result of present and future research.
6 Epilepsy occurs in many forms, and frequently presents a
7 very difficult problem in its management. In some
8 instances a number of different antiepileptics may be
9 used before a patient's seizures are adequately con-
10 trolled. Often the treatment finally chosen will
11 involve the use of several of these drugs simultaneously.

12
13 Mention has been made frequently of our
14 present day forms of treatment for the mentally ill.
15 The year 1934 marks the beginning of the present era of
16 progress in the treatment of psychiatric disorders. It
17 was in that year that Dr. Manfred Sackel introduced
18 insulin shock for the treatment of schizophrenia, a
19 disease which until then was usually looked upon as in-
20 curable, except for a small proportion of patients who
21 made spontaneous and unexplained recoveries. In
22 1935 Dr. L. J. Meduna introduced convulsive shock
23 therapy -- and therapy of course is synonymous with
24 treatment -- using a drug to produce the convulsions.
25 About a year later Dr. Hugo Cerletti successfully used
26 electric stimulation of the brain to cause the convul-
27 sions, and electroshock, as he called his treatment,
28 has remained the widely used psychiatric treatment
29 procedure to this day.

30 In the last few years, a whole new family



1 of drugs variously referred to as psychotropic drugs,
2 neuroleptics, etc., has made its appearance. It includes
3 the drugs popularly referred to as "tranquillizers".
4 In 1944, as a direct result of a carefully conducted
5 research program, the first clinically effective anti-
6 histamine drug was discovered. Within the next three years,
7 other antihistamines were developed in medical research
8 laboratories. It was observed that several of these
9 new drugs induced a marked degree of drowsiness and
10 sometimes lethargy and indifference. The possibility
11 of finding other compounds which might have even
12 greater effect on the functions of the brain and less
13 antihistamine effect was at once recognized. Some of
14 the most intensive research activity in medical history
15 was commenced at about this time. This resulted in the
16 discovery of chlorpromazine, the first radically new
17 approach to the treatment of mental illness since electro-
18 shock had been introduced. Chlorpromazine is a deriva-
19 tive of phenothiazine, a rather dangerous drug formerly
20 used for the treatment of human intestinal worms, and now
21 used only in veterinary practice. Following successful
22 clinical trials with chlorpromazine in 1952, many other
23 derivatives of phenothiazine made their appearance.
24 These drugs are collectively referred to as phenothia-
25 zine derivatives or simply "phenothiazines". A dozen or
26 more are now used for the treatment of mental illness and
27 others have become most valuable as antinotion sickness
28 (seasickness) remedies, antihistamines and other medicinal
29 remedies.
30



1 Chlorpromazine, like phenothiazine from which
2 it was derived, is not entirely without danger to the
3 patient. It may cause serious liver damage, with jaun-
4 dice, and a number of patients have developed serious and
5 even fatal blood disorders because of its action on
6 bone marrow. The incidence of such serious effects is,
7 fortunately, not great, but they were important factors in
8 stimulating the search for other effective drugs which
9 would be safer. We now have a wide variety of pheno-
10 thiazines and many new ones are even at this moment under-
11 going clinical trials. Much has been learned about the
12 use of these drugs and methods have been discovered
13 for the detection of adverse effects before serious damage
14 to the patient's system can occur. Some of the newer
15 phenothiazines have been found to have fewer dangerous
16 side effects, but may have unwanted effects that are un-
17 pleasant for the patient. It is also being observed that
18 the patient who fails to respond favourably to one pheno-
19 thiazine derivative may show great improvement when given
20 another.

21 Rauwolfia serpentina, a shrub which grows in
22 India and neighbouring countries, is the source of a
23 small but important group of drugs. The powdered, dried
24 root of the plant has been employed in these countries
25 for centuries to treat a variety of disorders,
26 including certain types of mental illness. A number of
27 very potent and active substances were extracted and iso-
28 lated about 1931, but it was not until 1952 that these
29 substances were actually used in the Western Hemisphere
30 for the treatment of the mentally ill. Reserpine is the



1 most widely used of the alkaloids in psychiatric practice.
2 Alkaloids are just highly purely potent extracts. The
3 whole root and another alkaloid, deserpidine, are also
4 used. These drugs have effects on other systems of the
5 body as well as on the functions of the brain. Never-
6 theless, when properly used, they have contributed
7 greatly to the success of our treatment of many
8 patients.

9 The use of drugs to treat many types of
10 depression is now commonplace, yet it was only three
11 years ago that Dr. Nathan Kline first reported the
12 successful treatment of depressed patients by
13 means of a drug, iproniazid, a very potent remedy for
14 tuberculosis. Iproniazid is, unfortunately, prone to
15 cause severe liver damage and for this reason has
16 fallen into disfavour. A number of other psychic
17 energizers, as these drugs are known, have been developed
18 and are now in general use in mental hospitals. Many
19 have such side effects as a tendency to cause a severe
20 fall in blood pressure when the patient stands up. Other
21 side effects, some quite serious, have also been
22 reported. Intense research is now being carried out
23 to produce new, safer antidepressant drugs. Several of
24 these are already undergoing clinical trial.

25
26
27 -
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1 THE CHAIRMAN: Any questions? Thank you,
2 Dr. Gunn. Dr. W. G. Brown?

3 DR. W. G. BROWN (Deputy Minister of Ontario
4 Department of Health): Mr. Chairman and members of
5 the Select Committee: this is a statement by our
6 department that relates to the procedures for procurement
7 and supply of drugs for hospitals administered by the
8 Ontario Department of Health.

9 There are nineteen hospitals throughout the
10 Province which are administered by the Department of
11 Health for the care and treatment of the mentally ill and
12 handicapped. In this report we will endeavour to outline
13 the procedure carried out with respect to the selection
14 of medication, the distribution and the procurement of
15 drugs for these hospitals.

16 SELECTION OF MEDICATION AND DISTRIBUTION

17 The first step is initiated by the staff
18 physician-psychiatrist, or consultant, following his
19 examination of the patient. The treatment or medication
20 needed for each individual patient is written in the
21 Doctor's Order Book and signed by the physician.

22 The ward supervisor then transcribes the order
23 onto each patient's Treatment Record Sheet and into the
24 ward Medication Book. The Medication Books are used by
25 the ward staff for treatments, administering of medica-
26 tions and ordering supplies from the hospital dispensary.

27 Each ward maintains an establishment of
28 medications in a locked cupboard or small medication room.
29 When supplies are depleted a further supply is drawn from
30 the dispensary in ward stock containers. The variety



1 and quantity of medications stocked on the wards varies
2 from hospital to hospital. One hospital limits ward
3 stock supplies to items used in quantity only. All
4 other less frequently prescribed medications are sent
5 to the ward in individual containers for each patient.

6 Each staff physician in Ontario Hospitals is
7 expected to familiarize himself with the stock of
8 medications in the dispensary and his orders for his
9 patients are selected from this supply unless some
10 specialty item is indicated. The medications stocked
11 in each dispensary are usually those selected by the
12 senior staff physicians who base their choice on their
13 experience in that particular hospital. Any physician
14 wishing to add a different item to the dispensary stock
15 discusses the subject with the Medical Superintendent
16 or Assistant Medical Superintendent. Each medication is
17 added according to its merit, and there are very few
18 duplications or quantities of "dead" items. Those that
19 do accumulate are now traded between hospitals where there
20 is a need for them.

21 More hospitals are adopting the Formulary
22 System. The Formularies are listings of all products
23 available in the dispensaries of the hospitals concerned
24 and range from simple therapeutic indexes to complete
25 product descriptions. These are available for easy
26 reference and in some cases copies are distributed to
27 each physician and each ward.

28 Medications for trial purposes are purchased on
29 the approval of the Medical Superintendent. The
30 quantities of these items are kept limited until some



1 pattern is established to indicate the extent to which
2 they will be used.

3 PROCUREMENT OF DRUGS

4 Drugs and medicines are procured for use in
5 Ontario Hospitals either by local hospital purchases or
6 by departmental purchases.

7 The local purchase method is only used in
8 emergencies - when supplies have run low, when there
9 is a delay in shipments, or when some situation arises
10 which necessitates an immediate supply of a drug or
11 medicine. In such cases the medical staff will request
12 the business office to procure the items. This is done
13 through local retail outlets on a competitive basis,
14 if possible. The dollar value of this type of purchase
15 is not great.

16 Prior to 1953, departmental purchases of
17 drugs and pharmaceutical supplies were made for the
18 hospitals on a three months' basis. They were requisitioned
19 by trade names by the hospitals, and the orders
20 were placed with the firms indicated as being preferred
21 by the hospitals. In 1953 this system was changed.
22 Ordering was put on a six months' basis rather than
23 the previous three months. This increased the volume
24 of purchases made at one time and thus reduced prices.
25 Also, several pharmaceutical houses indicated that they
26 could supply certain drugs and medicines at considerable
27 saving, if the drugs were ordered by the chemical or
28 generic names rather than by the trade names. Several
29 items in the general drug and pharmaceutical categories
30



1 were chosen and Quotation Requests covering these items
2 were sent to the interested suppliers. Competitive
3 prices were obtained and the items purchased from the
4 firms quoting the lowest prices. The results proved
5 very satisfactory, and this plan steadily expanded to
6 include all such drugs which were available from more
7 than one source.

8 The system generally now in effect is that all
9 hospitals, except three, requisition for supplies
10 semi-annually. Two of the three exceptions are small
11 establishments which indent from larger nearby hospitals
12 for their supplies. The third exception treats mostly
13 out-patients or short term illnesses and must therefore
14 order monthly. Provision is made, however, for any
15 drug in short supply to be requisitioned through the
16 Department at any time during the regular six months
17 purchasing period. The hospitals are supplied with
18 commodity sheets covering those drugs and medicines that
19 are in general use in Ontario Hospitals. You will
20 find a copy of these as Appendix A. These sheets are
21 similar in form to blank stock forms. There is space in
22 which to enter the respective quantities for each item.
23 Space is also provided for delivery dates to be shown.
24 These forms are prepared by the business office at the
25 hospital, on a semi-annual basis, according to infor-
26 mation as to requirements supplied by either the medical
27 staff or the drug committee at the hospital. When this
28 commodity sheet has been completed, a numbered
29 requisition is attached, checked and certified by the
30



1 Business Administrator, as to funds available, etc.,
2 and submitted to the Medical Superintendent for approval,
3 and forwarded to the Department. You will find a copy
4 of this document as Appendix B. Separate requisitions
5 are prepared covering those items required but not
6 included on the commodity sheets. When all requisitions
7 are received in the Department, they are recorded and
8 sent to the Mental Health Branch where they are reviewed
9 and signed by a senior medical officer. They are then
10 processed through the Department to the Purchasing
11 Office where they are grouped into the following
12 categories: -

- 13 1. General Chemicals and Pharmaceuticals
- 14 2. Analgesics, Narcotics & Sedatives.
- 15
- 16 3. Tranquilizers
- 17 4. Biologicals
- 18 5. Trade Name Brands.
- 19

20 As each of the first three categories becomes
21 complete, that is when a requisition has been received
22 from each hospital, Quotation Requests are prepared
23 and issued, in duplicate, to the suppliers. You
24 will find a copy of this is attached as Appendix C.
25 Some of these Quotation Requests go to as many as sixty
26 suppliers at one time. We mention this to show that,
27 where possible, competition is invited. The office
28 copy of the Quotation Request on which is shown a list
29 of the firms to whom it has been sent, is forwarded to
30 the Office of the Comptroller where it is entered in a



1 registry. This registry lists the name of the hospital
2 concerned, the number of the requisition, the type of
3 goods being quoted on, the list of the firms, the date
4 the Request is mailed and the date it is to be returned.
5 This copy is retained in the Comptroller's Office.
6 When the forms are returned by the suppliers, they are
7 stamped the day they are received, recorded in the
8 above-mentioned registry and held with the office copy
9 until the date on which the prices were requested to be
10 returned. They are then collectively sent to the
11 Purchasing Office for processing. This involves pre-
12 paring spread sheets showing the names of the firms who
13 replied, the names of the drugs and the competitive
14 prices on each, along with any other pertinent information.
15 These spread sheets are then reviewed by the senior staff
16 in that office, and the prices of the items selected for
17 purchase are checked off. This information is transferred
18 to the Quotation Request of the firm who will receive the
19 order. The order forms, original and five copies, are
20 then typed for each hospital, checked and certified by
21 the Officer in Charge of Purchasing. The order number
22 is then shown opposite the items on the Quotation Request,
23 as well as on the requisition or prepared commodity
24 sheet. The original of the order is then mailed to the
25 supplier. The data from the second copy of the order
26 is entered in the order number book and the copy is then
27 placed in the file under the name of the hospital for
28 which the order was placed, and filed alphabetically under
29 the firm name, in numerical order. The other four copies
30



1 are mailed to the hospital for their records. Each
2 requisition and Quotation Request is properly filed
3 when all items have been ordered.

4 Drugs in categories one and two have, for
5 sometime, been ordered from the firms quoting the best
6 prices. There are, however, instances where
7 exceptions are made and the items purchased from a
8 specified supplier, at the request of the hospitals.
9 This is when a complaint has been received from a hospital
10 that an item previously supplied was not entirely satis-
11 factory. Colour or size variation of a tablet may be
12 a factor, as it has been reported that this has a
13 psychological effect on patients.

14 With respect to category three (tranquilizers),
15 when these drugs first came on the market, they were
16 available only from the originator and were supplied
17 under a trade name. As the demand increased, several
18 firms asked for the opportunity to quote on our
19 requirements and subsequently Quotation Requests were
20 issued, using the generic names. Competitive prices
21 were obtained and orders issued to the supplier quoting
22 the best price. This procedure continued for sometime,
23 when hospitals advised that the medical staff were
24 concerned as to whether the patients were receiving full
25 benefit from the lower priced drugs.



1 This was about the time we would be ordering the April
2 '58 supply and, in view of the concern expressed, a
3 departmental decision was reached whereby one-half
4 of each order would be placed with the originator or a
5 licensed originator of a drug and the other with the
6 firm quoting the lowest price. This was done to enable
7 the hospitals to make a comparison between the drugs
8 manufactured by the original supplier and those
9 manufactured by other firms. This same procedure
10 was carried out when ordering the October '58 require-
11 ments. Just prior to issuing orders for our April
12 '59 requirements, further complaints were received
13 from the hospitals that some drugs supplied on the
14 previous orders did not appear to be up to standard.
15 Several samples of the drugs were sent to the Department
16 from the hospitals and these in some instances revealed
17 discoloured and broken tablets and some of the ampules
18 were only partially filled, also some of these had
19 changed colour.

20
21 The Department then took the definite stand
22 that all tranquilizers should, for a period, be pur-
23 chased from the original suppliers, while arrangements
24 were being made whereby the Department could establish
25 quality control.

26 It was first thought an attempt would be made
27 through our Provincial Health Laboratory to test all
28 drugs purchased, but after considerable discussion
29 and negotiations, arrangements were completed between
30 the Honourable the Minister of Health and the



1 Attorney-General whereby the services of officials of
2 the Attorney-General's Laboratory would be available for
3 the purpose of preparing standard specifications on drugs
4 required by this Department, as well as to carry out
5 the necessary tests in their Laboratory. This would
6 ensure that the product supplied would be in line with
7 what is needed by the medical staff to treat their
8 patients, and at the same time we would have a guarantee
9 that we were not receiving an inferior product when the
10 lowest price is accepted.

11 Recently specifications were prepared for all
12 tranquilizer tablets which are used in Ontario Hospitals
13 and which may be procured under generic names. Tests
14 were run on three items - Reserpine 0.25 mg.,
15 Reserpine 1 mg. and Meprobamate 400 mg. - which were
16 ordered from the firms quoting the best price. The
17 orders were placed with instructions that they be
18 shipped to our holding depot where they would be kept
19 pending the results of the tests. It was understood
20 by the firms supplying these items that, should the
21 drugs not meet the specifications to our satisfaction,
22 they would be returned and a credit voucher, in favour of
23 the hospital concerned, would be issued by the firm.
24 When tests revealed the drugs to be satisfactory, the
25 goods were trans-shipped to the respective hospitals.

26 We have just placed orders to cover the
27 current six months' supply of tranquilizers (that is,
28 those procurable under generic names from competitive
29 sources). They have been ordered on price and will be
30



1 sent to our holding depot pending the results of the
2 necessary tests carried out by the Attorney-General's
3 Laboratory. If any one of the items is not satisfactory,
4 it will be returned, as mentioned above, and re-ordered
5 from the firm giving us the next best price, subject to
6 the same test. All firms quoting on these tran-
7 quillizers certified they were agreeable to the return
8 of items which did not meet the specifications to the
9 satisfaction of this Department.

10
11 It is our intention to expand this program
12 to include as many of the drugs used in Ontario
13 Hospitals, as possible, thereby guaranteeing the quality
14 of the products and at the same time allowing us to take
15 advantage of the best prices.

16 In connection with those drugs shown under
17 category four, that is, biologicals, these are
18 procured from the Connaught Laboratory which is part
19 of the University of Toronto. We are supplied with a
20 price list of all biologicals which can be procured
21 from this source and they are obtained in this manner.
22 The regular departmental order forms are used for
23 these purchases.

24 It is not possible to obtain items, listed
25 under category five, that is the brand name or the
26 pharmaceutical specialty, on a competitive price basis.
27 These are only obtainable from the one source. They
28 are ordered by trade names and are priced from
29 catalogues, by telephone or by letter. However, we
30 have been successful in arranging for some companies



1 to grant us special prices. In some instances the drugs
2 were not packaged in containers of more than 500 or
3 1,000 tablets and the prices set accordingly. As we
4 order many of these items in greater quantities, we
5 arranged with some firms to have their packaging
6 altered and thus reduce their prices. Other firms
7 who use a sliding scale price list based on the quantity
8 ordered, granted us the best price listed, irregardless
9 of quantity ordered. Other companies have granted
10 us a discount price based on the total quantity of
11 drugs purchased during a six or twelve months period.
12 At the end of such period they issue a credit note
13 or cheque to each hospital covering this discount.
14 Current discounts on some drugs range from 3% on
15 purchases of \$5,000 to as high as 13% on purchases
16 over \$70,000.

17
18 When drug shipments are received at the
19 stores depot of the respective hospitals, they are
20 recorded in the Receiving Book as to the supplier
21 and the number of parcels in the shipment. No cartons
22 are opened in the stores. Shipments are delivered to
23 the dispensary as soon as possible after they are
24 received at the stores. The cartons are then opened
25 and the contents checked against the packing slips by
26 the dispensary personnel. Invoices, when received,
27 are passed through the stores to the dispensary.
28 They are checked and receipted by the person in charge
29 of the dispensary before payment is made by the
30 business office.



1 Mr. Chairman, in submitting this statement,
2
3 I assumed that you are aware and members of the
4 Committee are aware that our departmental policies
5 are such and the operation of our hospitals is such
6 that there is no sale of drugs to people. They are
7 supplied free of charge.

8 MR. WREN: Will you discuss these quotation
9 requests you mention here. From your experience,
10 what variation was there in prices quoted for a given
11 drug?

12 Say you received, as an example, twelve
13 quotations back for a given kind of pill. What
14 variation in prices would there be?

15 DR. BROWN: In some instances, considerable
16 variation. In others, very little variation.

17 MR. WREN: How serious are the variations?

18 DR. BROWN: I wonder if my controller might
19 speak on that. He is acquainted with this. I wonder
20 if that would be permissible? He is Mr. Tattle from
21 our Department.

22 THE CHAIRMAN: Yes.

23 Mr. Tattle, for the record would you give us
24 your full name.

25 MR. TATTLE: G. S. Tattle, Controller,
26 Department of Health.

27 THE CHAIRMAN: And in your capacity in
28 that position, are you familiar with this procedure?

29 MR. TATTLE: I am, sir.

30 MR. WREN: What kind of a drug or pill would



1 you define as a wide variation in quotation?

2 MR. TATTLE: I cannot speak just off the cuff,
3 as it were, to enumerate a large number, but I would
4 say in every spread sheet that was prepared, there is
5 quite a variation between the lowest price and the
6 highest, particularly in the newer drugs. Some of the
7 older drugs, like aspirin, show very little variation,
8 a matter of only a few cents per thousand.

9 In some of the more recent drugs, the tran-
10 quillizers, for instance, might have quite a spread.

11 MR. WREN: Do you have any examples?

12 MR. TATTLE: No, I did not bring anything with
13 me. We are preparing for this Committee a complete
14 analysis of all drugs purchased during the last
15 fiscal year, and will be able to show to you gentlemen
16 in time every drug that we purchased, the price paid
17 for every drug, and I think that will reveal the
18 answer Mr. Wren is asking.

19 THE CHAIRMAN: That survey is going on now?

20 MR. TATTLE: That is going on at the present
21 time.

22 THE CHAIRMAN: That will be available this
23 week, or at a later date?

24 MR. TATTLE: If we knew exactly what
25 form you wanted it in, we could provide it for you
26 later on.

27 MR. WREN: I am particularly interested in
28 knowing or seeing some of the actual examples of the
29 spread in prices quoted.
30



1 MR. TATTLE: If it is the wish of the
2 Committee, we could easily submit one spread sheet, if
3 you wish. If you want to check any particular drug,
4 we can produce it in five minutes.

5 THE CHAIRMAN: I think, Mr. Tattle, when
6 you are arranging for this survey to which you have
7 referred, I think some attention might be given follow-
8 ing the development of the purchases listed in the
9 various texts that Dr. Brown has described, so that
10 you will have some specific examples following the
11 texts.

12 MR. TATTLE: We could very easily set up
13 this table into the five categories as shown there,
14 very easily.

15 THE CHAIRMAN: Would you do that.

16 MR. TATTLE: Yes.

17 -----
18

19
20 DR. WARD SMITH, Called

21
22 THE CHAIRMAN: You are a member of the
23 Attorney-General's Department.

24 MR. SMITH: Yes, Mr. Chairman, and a
25 graduate of the Attorney-General's Laboratory.

26 Mr. Chairman and Members of the Select
27 Committee, it is my privilege to introduce the tests,
28 standards and specifications of the drugs which we
29 are currently developing in the Department of Public
30



1 Health. This was requested of us. Mr. Brooks of
2 the Laboratory conducts this work.

3 I thought it well that in the introducing
4 of the topic of these standards, to point out what
5 the standards do not do. They do not test the
6 action of the drug, that is the purpose for which it
7 is being used. Nor does it test, for example, any
8 peculiarities of this particular kind of medication,
9 for example. We do not, therefore, touch on the
10 reasons for the choice of a particular drug which has
11 been outlined here very admirably by Dr. Gunn.

12 This applies equally to the physical factors
13 that have to do with the drugs, that is the kind of
14 active ingredient that is there, and also the effects
15 of some of the other materials which combined together
16 make a tablet.

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1 Some people have peculiar reactions to this.
2
3 I think in order to emphasize the things that we do not
4 do in the laboratories, and what really the prescribing
5 physician alone is in a position to do, I would like
6 to review just for a moment, some of the points that
7 Dr. Gunn has made in his text. I will keep to the
8 text as much as possible Mr. Chairman.

9 On Page 4, he has outlined that any physician
10 must be permitted to prescribe the drugs that he believes
11 to be indicated or effective for the particular illness
12 and for the particular patient that he is treating.
13 This of course means -

14 THE CHAIRMAN: Just a moment, until I
15 find it.

16 DR. WARD SMITH: This is on Page 4, Mr.
17 Chairman, under the topic "Drugs". This is the
18 second paragraph, second sentence. This will mean
19 a multiplicity of drugs and which on face value might
20 appear to have essentially the same action, and yet
21 for some purposes, one of these will be preferable to
22 another.

23 This situation is further complicated in the
24 words of Dr. Gunn: "People vary greatly in their
25 physical as well as their mental make-up...." The last
26 sentence in this page, "...and they differ in the way
27 that they respond to various drugs." This is true
28 of all the drugs of the study, to some extent or
29 other, and again will make a basis for choice between one
30 preparation, if you will, as opposed to another.



1 In addition to this, some people are
2 sensitive to the materials which form the binder in some
3 type of preparation, and therefore, even though the
4 preparation may have the same essential ingredient, the
5 binder might be different, and occasion the reason for
6 choice for that particular patient.

7 This he has outlined on Page 5, the last
8 sentence in the paragraph on top of the page, "the
9 physician's choice would depend on his personal knowledge
10 of this patient as well as his knowledge and experience
11 with the various drugs at his disposal."

12 With respect to some of the herbal extractions,
13 this would be almost impossible to test in any factual
14 way, except to determine purity and as indicated here
15 on Page 6, middle of the second paragraph, "Often there
16 is little or no difference whatsoever in the products of
17 the various manufacturers and governmental control
18 ensure that they all meet the required standards of
19 purity and potency. There may, however, be subtle
20 differences in colour, consistency, flavour or
21 presentation", and these subtle differences might
22 well be important to both the physician and patient.

23 I think the control of this situation, with
24 respect to choice of different products has been outlined
25 in the method of serum supplied by Dr. Brown, and I
26 think we must bear in mind the point that Dr. Gunn
27 makes on the bottom of page 7, and that is, that many
28 drugs have been developed and introduced which have
29 highly selective action and which have an application
30



1 limited largely, if not exclusively, to specialized
2 practice. Thus each specialist consultant may require
3 a number of drugs to be available which are unlikely to
4 be used by any other member of the staff, but all of
5 these may be quite essential to the adequate care of
6 the patients in the hospital.

7 The last point that I wish to emphasize,
8 although there are many other valuable ones in this
9 presentation of Dr. Gunn, is the bottom of Page 15.
10 He has illustrated this with the effects of
11 chlorpromazine, in the last paragraph:

12 "Cholorpromazine, like phenothiazine from which
13 it was derived, is not entirely without danger
14 to the patient. It may cause serious liver damage,
15 with jaundice, and a number of patients have
16 developed serious and even fatal blood disorders
17 because of its action on bone marrow."

18 I think this sentence indicates that though
19 main drugs, there are those who do not respond
20 effectively to them, and again, while this drug is
21 extremely useful in some situations, some people may
22 not tolerate it, and so again, there is a requirement
23 for multiplicity of drugs, each with, you might say,
24 the same or similar basic action.

25 Now these are things that are not being tested
26 in the testing programmes. You have things that are
27 being tested, which of course, to return to our text,
28 the things that are being tested are designed to ensure
29 proper identity, strength, quality, purity and uniformity
30



1 of the various pharmaceutical preparations as submitted
2 by the Department of Health.

3 In other words, we only come into the
4 picture when the Department of Public Health has made
5 a purchase under the terms that Dr. Brown has outlined.
6 We sample that material according to the tests which
7 Mr. Brooks will outline. On the basis of those tests,
8 write a factual report which is submitted to the
9 Department of Public Health. I take it, from there,
10 our responsibility in the matter ends.

11 As to the tests themselves, I will call on
12 Mr. Brooks to make a presentation. I will be available
13 for questions, if necessary.

14 THE CHAIRMAN: Before we go on with Mr.
15 Brooks, we will have a five minute recess.

16 --- SHORT RECESS.

17 --- FOLLOWING SHORT RECESS.

18
19
20 MR. G. E. BROOKS: Mr. Chairman, members of
21 the Select Committee, the Attorney-General's
22 Laboratory, upon the request of the Department of
23 Health, agreed to recommend standards and conduct
24 analyses on various pharmaceutical preparations submitted
25 by the Department of Health.

26 These standards or specifications are
27 designed to ensure proper identity, strength, quality,
28 purity and uniformity of the various pharmaceutical
29 preparations as submitted by the Department of Health.

30 Such standards are necessary because large-



1 scale pharmaceutical production presents many problems
2 and conditions which make it a complicated operation.
3 e.g. The preparation of a plain white tablet involves
4 several steps and requires several days. Usually
5 several operations are in progress at the same time,
6 frequently in different sections of the factory where
7 similar operations involving other drugs and other dosage
8 forms are also in progress. Further complications
9 arise due to the sensitivity of many compounds to air,
10 light and moisture during manufacture and subsequent
11 storage. Therefore, to protect patients from any
12 possibility of human error or chemical changes some system
13 of analytical control is necessary.

14 Many companies have established intricate
15 control organizations to ensure the reliability of their
16 products, and the testing done in the Attorney-General's
17 Laboratory is an added safeguard. Some companies do not
18 have an adequate control organization and in such cases
19 the testing done in the Attorney-General's Laboratory is
20 an essential safeguard.

21 To illustrate the type of standards which have
22 been recommended, a copy of the proposed specifications
23 for a table containing 2 mg. of reserpine is included,
24 at the end of this submission.

25 Reserpine 2.0 mg. tablets.

26 Assay - Reserpine 2.0 mg. tablets shall contain not
27 less than 1.8 mg. and not more than 2.2 mg. of
28 reserpine ($C_{33}H_{40}N_2O_9$) as determined by the official
29 method of assay described in U.S.P.XVI.
30



1 Identification - Reserpine 2.0 mg. tablets shall
2 give the identification reactions for Reserpine
3 Tablets U.S.P. XVI.

4 Limit for Other Alkaloids - Reserpine 2.0 mg.
5 tablets shall pass the test for absence of other
6 alkaloids in Reserpine Tablets U.S.P. XVI.

7 Disintegration Time - Not more than 1 hour when
8 determined by the official method described in
9 U.S.P. XVI.

10 Weight Variation - Reserpine 2.0 mg. tablets
11 must meet the U.S.P. XVI. limits for weight variation.

12 Packaging & Storage - Reserpine 2.0 mg. tablets
13 shall be preserved in sealed amber glass bottles
14 containing 1000 whole tablets each, and labelled to
15 indicate clearly the contents including the lot
16 and/or control number, and packaged in light-
17 resistant containers labelled to indicate clearly
18 the contents including the lot and/or control number.

19 Food and Drug Regulations - Reserpine 2.0 mg.
20 tablets must conform to Food and Drug Regulations
21 governing labelling, colours, etc. and in all
22 other respects not specifically indicated in these
23 specifications.

24 Submission - When submitting a tender for
25 Reserpine 2.0 mg. tablets a manufacturer must also
26 submit a confidential complete formulation of
27 the product.

28
29 The limits proposed therein closely parallel
30 the standards set forth in the British and United States



1 Pharmacopoeias.

2 Under the heading "Assay" the product required
3 is defined, and limits of potency corresponding to the
4 United States Pharmacopoeia standards are stated.

5 A difference of plus or minus 5% from the labelled
6 strength is permitted to allow for analytical error, for
7 unavoidable variations in compounding and manufacture and
8 for deterioration to a minor extent considered insigni-
9 ficant under practical conditions. The molecular
10 formula is used in defining the required strength to
11 designate a substance of absolute purity. In practice
12 a drug containing a small amount of moisture may be
13 preferable for actual compounding and this may be used
14 providing the amount taken is equivalent to the stated
15 amount of absolutely pure drug.

16 The improved techniques of isolation and the
17 refinements in quantitative instrumental measurement
18 provided in the latest editions of the British
19 Pharmacopoeia and U.S. Pharmacopoeia have been adopted
20 whenever possible. However, with the number of new
21 drugs currently being introduced, it is inevitable that
22 official methods of analysis will not yet be provided for
23 many products currently in use. In such cases the
24 analytical procedures recommended by the Food and Drug
25 Laboratories at Ottawa are followed.

26 During the past decade the technology of drug
27 analysis has undergone a remarkable transition. Chemical
28 analyses have attained a high level of precision and
29 sensitivity albeit at a decided loss of simplicity.
30



1 Further, the wide variety of material used in medicine
2 necessitates a great number and variety of tests. To
3 facilitate extractions and testing a confidential
4 formulation of the product is requested. This permits
5 testing to proceed without delay and assures more prompt
6 delivery of drugs to various hospitals. In addition
7 such formulations protect manufacturers from possibilities
8 that fillers or binders may interfere with instrumental
9 measurements.

10 The testing of drugs for medicinal use requires
11 a well-trained staff, properly equipped for practically
12 every type of analysis.
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1 The Attorney-General's Laboratory is particularly for-
2 tunate in having experts in many branches of science.
3 I might add that there are three pharmacists, two with
4 Master's degrees as well as many of the latest
5 analytical instruments. However, much specialized
6 equipment is required for testing drug preparations,
7 some of which has already been provided, e.g., a tablet
8 disintegration apparatus, potentiometric titrometer,
9 constant temperature water bath, etc.

10 The identification tests described or
11 referred to under this heading are provided to confirm
12 the identity of the drug. While one of the primary
13 objects of this program is to assure the users of
14 these products of the identity of the drug, it is mani-
15 festly impossible to include in each specification a
16 test for every impurity or adulterant that could be
17 present. Therefore, tests suitable for detecting
18 impurities whose presence is not consistent with
19 good pharmaceutical practice may be employed in
20 addition to the tests provided. Since it is impos-
21 sible to prepare satisfactory finished products from
22 inferior or second-rate raw materials, the limit for
23 other alkaloids has been included to direct attention
24 to those impurities which are most likely to appear
25 with materials extracted from vegetable sources, and
26 to fix limits for those which are tolerated only to
27 a given extent.

28 The disintegration time limit assures the
29 user that the tablet will break down within a reasonable
30



1 time to release the medication, and that the tablet
2 will not pass through the intestinal tract without
3 dissolving. Short disintegration time also helps
4 avoid the possibilities of drugs accumulating in the
5 intestinal tract, and the subsequent dangers of
6 overdosage as the medication becomes eventually
7 absorbed.

8 The weight variation test assures the users
9 of uniform doses, and indicates that adequate super-
10 vision of the tableting process was maintained
11 throughout this operation.

12 The containers described under packaging and
13 storage are designed to prevent deterioration of the
14 contents beyond the recommended limits of strength,
15 quality or purity under the ordinary conditions of
16 handling, shipment and storage. A tight container
17 further protects the contents from contamination by
18 moisture, dust or vapours, and protects against the
19 loss of volatile ingredients under ordinary conditions.
20 A seal is recommended for each bottle to prevent
21 incidental tampering with the contents between the
22 manufacturer and the consumer.

23 In drafting specifications for the Department
24 of Health we did not wish either by omission or
25 ambiguity, to give license to manufacturers to contra-
26 vene any of the regulations of the Food and Drug
27 Act which are designed to protect the consumer.

28 Specifications are set up for each pharma-
29 ceutical preparation submitted by the Department of Health.
30



1 The exact details of the standards recommended and the
2 testing methods employed vary according to the drug in
3 question and the strength and form of the product
4 desired. The example given, I think, will illustrate
5 in general the approach.

6 In practice the overall program functions
7 as follows:

- 8 (1) The Department of Health submits a request for
9 specifications for a Product "X".
- 10 (2) The Attorney-General's Laboratory studies the
11 requirements for a Product "X" and submits a set
12 of proposed specifications to the Department of
13 Health.
- 14 (3) After some time the Attorney-General's Laboratory
15 is informed that a supply of Product "X" has been
16 delivered to the drug reception center at the
17 Ontario Hospital, 999 Queen Street West, Toronto.
- 18 (4) A drug analyst from the Attorney-General's
19 Laboratory gains admission to the drug reception
20 center and samples the shipment according to
21 approved random sampling procedures.
- 22 (5) The samples so obtained are tested thoroughly
23 according to the methods described in the
24 specifications proposed earlier.
- 25 (6) A factual report of the laboratory findings is
26 sent to the Department of Health without any
27 recommendations.

28 That is the programme of the Department of
29 Health. It costs money and if the Committee is
30



1 interested, and if you wish to ask any questions we
2 will try to give some answers.

3 MR. WREN: I would like someone in the
4 Department to answer this question. A great
5 deal of attention is paid to the costs of drug
6 materials going into Ontario hospitals. What protec-
7 tion does the Department offer by way of examinations
8 or analyses of drugs going into retail outlets or to
9 other hospitals? Is there any programme to protect
10 them?

11 MR. BROOKS: I can answer it by saying that
12 so far this programme has included drugs which have
13 been supplied to Ontario hospitals, and the full
14 scope of the programme which will probably develop
15 over the next year or so, but that is beyond the scope
16 at this time.

17 MR. WREN: I just wondered if there might
18 be any tendency for a supplier to give particular
19 attention to the drugs or pills going into Ontario
20 hospitals, and maybe not such particular attention to
21 a product going elsewhere.

22 MR. BROOKS: I think the Food and Drugs
23 director is concerned with that aspect.

24 MR. WHITE: It was mentioned on page 2 that
25 some companies do not have an adequate control organiza-
26 tion and in such cases the testing is done in the
27 Attorney-General's Laboratory. The question occurs to
28 me it would soon be found that if suppliers to the
29 Department of Health consistently supplied an inferior
30



1
2 product, would they be removed from the approved list
3 of dealers, or something of the sort?

4 MR. BROOKS: I cannot say. That is
5 beyond the scope of our Department.

6 THE CHAIRMAN: Would you ask the question
7 of Mr. Tattle?

8 MR. WHITE: Will I repeat the question?

9 THE CHAIRMAN: Are there any other ques-
10 tions of Mr. Brooks, first? Thank you.

11
12 ----

13
14 MR. TATTLE, Recalled

15
16 MR. WHITE: Mr. Brooks has mentioned in
17 his brief that some drug companies do not have adequate
18 control methods, and he has further stated that in
19 such cases the testing done by his Department is
20 essential.

21 Several questions occurred to me, first of
22 all, if a drug company consistently supplied an
23 inferior product, and if their supplies were rejected
24 time and time again, would they still be permitted to
25 quote?

26 MR. TATTLE: Mr. Chairman, in answer to
27 that question, I will have to say it is an entirely
28 new procedure that we have introduced into the
29 Department in the last year, and we have not run into
30 the difficulty you speak of. However, I am quite



1 certain that if there are repeated offenders, I presume
2 the Departmental policy would be to deal with them in
3 the same way as they do with other matters, which would
4 be to remove them from the list. But up to now we
5 have not had this occasion.

6 MR. WHITE: Is there a list of approved
7 drug suppliers?

8 MR. TATTLE: They are not approved
9 suppliers. They are people interested in submitting
10 prices to the Department. All companies are permitted
11 to bid. Anyone who shows an interest in wanting to
12 quote their product can bid.

13 MR. WHITE: And the low bid is taken?

14 MR. TATTLE: That is right.

15 MR. WHITE: Even if that company might
16 have had a poor performance record in the past?

17 MR. TATTLE: Oh no. I think if you will
18 refer back to Dr. Brown's statement, he said in
19 general the lowest price was accepted in one or two
20 classifications; but he also qualified that by stating
21 that if there was objection from the hospital, stating
22 that a previous shipment was not satisfactory, if
23 there was something about the pill or tablet that was
24 not acceptable, it is common practice to use another
25 product.

26 In other words, even though the lowest
27 might be from one company not acceptable to the
28 hospital, we would move up to the next one. It might
29 be a matter of a fraction of a cent difference.
30



1 MR. BRYDEN: I do not know if Mr. Tattle
2 can answer this question, but I am sure one of the
3 gentlemen here can.

4 In the period in which this programme of
5 testing by the Attorney-General's Laboratories has
6 been in effect, what has been your experience with
7 objections?

8 MR. TATTLE: Mr. Chairman, as I mentioned
9 earlier, we introduced this scheme during 1959. It
10 took some time to get all the machinery in operation,
11 staff matters and so on. The Attorney-General had
12 to obtain additional staff, for one thing.

13 At the present time, we have completed four
14 specifications covering all tranquilizer tablets which
15 are used in the Ontario hospitals, three different
16 drugs which have been mentioned in the report have
17 gone through the testing procedure.

18 We purchased those drugs from three companies
19 which quoted us the best price, and I might say that
20 each one of the three drugs passed the test satis-
21 factorily.

22 That is the only experience we have had.
23 That was last December.

24 We are in the throes, as we have indicated
25 in the report of a test of a shipment which we have
26 just ordered for the current six months' period.
27 That order went out in the last month, and if the
28 drugs are being shipped to the receiving depot by the
29 various firms who received the order, they will be
30



1 going through the Attorney-General's Laboratory.

2 We have not heard about that as yet. As a
3 matter of fact, the companies who were successful in
4 getting the quotation, -- I do not presume they have
5 shipped them as yet. Naturally the quantities would
6 be large in many cases.

7 MR. BRYDEN: Is it the intention as this
8 programme develops, to test both products that are
9 supplied under a brand name and those that are supplied
10 under generic names?

11 MR. TATTLE: At the present time the
12 policy is that we are progressively going to move on
13 to as many drugs as possible for testing purposes, to
14 ensure that the doctors in the hospitals will have a
15 drug which they have confidence in.

16 That was the trouble that we had before, as
17 mentioned in the report previously, that we had some
18 sad experiences. So this way it will be not only a
19 matter of price, but also the assurance that the doctors
20 are getting what they want to treat the patients.

21 THE CHAIRMAN: Did your sad experience
22 arise specifically with respect to goods purchased
23 under trade or under generic names?

24 MR. TATTLE: No, they resulted from the
25 generics.

26 THE CHAIRMAN: From the generics?

27 MR. TATTLE: That is correct. We purchased
28 drugs through various companies -- without mentioning
29 any names as to some particular drug or drugs -- and
30



1 the hospitals complained that they were not -- and did
2 not appear to be -- up to standard.

3 We had samples sent in to the Department,
4 and it was obvious there was not sufficient care
5 exercised in the handling of the different coloured
6 tablets and so on, so the Department took a definite
7 stand that we then had to get in to testing drugs, and
8 the only way we could do it and at the same time
9 protect all the patients, was in our testing laboratory.

10 THE CHAIRMAN: In consideration of the
11 cost of the drugs, of course now today we have this
12 laboratory testing centre. Of course that is really
13 included in cost, too, isn't it?

14 MR. TATTLE: That would increase the cost,
15 I presume. The Attorney-General's laboratories would
16 have to be included.

17 THE CHAIRMAN: At any rate that is cost.

18 MR. TATTLE: It would be cost, there is no
19 question about that. We are buying several million
20 pills.

21 THE CHAIRMAN: Thank you.
22
23
24
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26
27
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1
2 DR. STEFAN GRZYBOWSKI (Medical Specialist,
3 Ontario Department of Health); Up to fifteen years ago
4 there were no specific drugs in treatment of tuberculosis.
5 Toward the end of the last century the idea of treating
6 tuberculosis by violent exercise was slowly abandoned
7 and was replaced by bed rest under sanatorium conditions.
8 Later on, collapse therapy, headed by artificial pneumo-
9 thorax was introduced. These measures resulted in the
10 saving of numerous lives, but even in many early, not-too-
11 far-advanced cases, tuberculosis was still a fatal
12 disease. Surgery at that time consisted for practical
13 purposes of the operation of thoracoplasty -- a form
14 of collapse treatment; resection of the diseased part
15 of the lung was fraught with such great dangers of
16 complications that it was rarely attempted.

17 Great hopes were therefore raised among
18 the sufferers from tuberculosis, as well as among
19 doctors responsible for the treatment of the disease,
20 when in 1945 the news reached them of the first clinical
21 trials of streptomycin, which Dr. Waksman isolated from
22 the fungus (*Streptomyces griseus*).

23 The history of the next fifteen years has
24 shown that these hopes have been largely fulfilled;
25 tuberculosis is nowadays rarely fatal, although it is
26 still serious and often requires prolonged and
27 competent treatment. When this is said it should be
28 realized that the perfect drug for the treatment of
29 tuberculosis is yet to come, for effective as they are
30 the present drugs are still relatively weak when compared



1 with the action of antibiotics in the treatment of many
2 other infections.

3 CHIEF ANTITUBERCULOSIS DRUGS

4 There are three main drugs used in the treat-
5 ment of tuberculosis -- streptomycin, isoniazid and
6 PAS (Para-aminosalicylic acid).

7 Treatment with only one of these drugs so
8 frequently leads to the emergence of resistance of
9 the tubercle bacilli to that drug that, except under
10 specific circumstances, the drugs are used in combina-
11 tions. There is still no uniform agreement whether all
12 three drugs should be used together in the initial
13 stages of treatment -- they are used in that way in the
14 Toronto Hospital, Weston, or whether it is sufficient
15 to use two-drug regimens.

16 With the acquisition of experience and
17 knowledge in the treatment of tuberculosis with these
18 drugs there has been a notable tendency towards treat-
19 ment for longer periods of time. At present the
20 average duration of drug treatment varies between
21 eighteen and twenty-four months, although some types of
22 disease are treated much longer -- sometimes indefinitely.

23 Streptomycin is given by injection in the
24 dosage of one gram. In most centres only two injections
25 are given each week; in some, streptomycin is given
26 daily. There is uniform agreement that sulphate salt
27 of streptomycin should be used as this causes much less
28 pain on injection.

29 Nurses giving injections of streptomycin must
30



1 wear rubber gloves and take other precautionary measures
2 in order to avoid frequent contact dermatitis. The main
3 toxic effects of streptomycin relate to its action on
4 the vestibular part of the VIII cranial nerve. This
5 nerve is responsible for the sense of balance and people
6 in which it is damaged by streptomycin complain of
7 dizziness and walk unsteadily. (When large doses of
8 streptomycin were employed in the United States at
9 the beginning of the antibiotic era it was said that
10 when a waiter spilled a plate of soup on the customer's
11 trousers the diagnosis was "tuberculosis". This nerve
12 damage occurs more commonly in older people, and older
13 people should not be given daily streptomycin for
14 more than a few weeks. Allergic reactions to
15 streptomycin manifested as various skin rashes are
16 relatively common.

17
18 Dihydrostreptomycin, a close relative of
19 streptomycin, was used until recently, but as it
20 causes deafness its use has been restricted.

21 Isoniazid (INH, "Rimifon") is probably the
22 most powerful antituberculosis agent available. It
23 can be given by mouth and the average dose is 300 - 400
24 mgm. a day. With this dose toxic effects are uncommon
25 and it is necessary to discontinue this treatment in
26 less than one per cent of patients. The toxicity,
27 when it occurs, affects the nervous system; peripheral
28 neuritis, psychosis, and convulsions, are the most
29 important among these toxic reactions. They can often
30 be prevented by the concomitant administration of 50 - 100



1 mgm. of pyridoxine (vitamin B6) a day. Unfortunately
2 this preparation is expensive and is not used widely in
3 the routine treatment of tuberculosis in Ontario.
4 Allergic skin reactions are seen very rarely with
5 isoniazid.

6
7 .Some authorities use isoniazid alone in the
8 treatment of tuberculosis. While this may be justified
9 in preventive treatment of recently infected individuals
10 with no evidence of tuberculous disease, the present
11 evidence indicates that one should be very cautious
12 with this form of therapy lest the strains of tubercle
13 bacilli resistant to isoniazid become a major public
14 health problem, with a consequent loss of effect-
15 iveness of this powerful therapeutic agent.

16 Para-aminosalicylic acid (PAS) is commonly
17 used as a companion drug to either streptomycin or
18 isoniazid; its effectiveness against tubercle bacilli
19 is of a lesser degree than that of either one of the
20 other two drugs. There are indications that apart
21 from its relatively weak antituberculosis action on its
22 own it enhances through a biochemical process the
23 effectiveness of isoniazid in combined treatment.
24 Digestive troubles, such as loss of appetite, nausea,
25 vomiting, abdominal distension and pain, and diarrhea
26 occur in about fifty per cent of patients. Fortunately,
27 in the majority, these disturbances are relatively
28 mild, and with enthusiasm and enterprise on the part
29 of the physician, and character stamina and adequate
30 motivation on the part of the patient, minor upsets



1 are usually tolerated. The degree of toxicity varies
2 with the size of the dose, the type of PAS salt which
3 is used, the age and degree of discolouration of the
4 solution, etc.

5 Owing to the frequent digestive intolerance
6 many preparations of PAS are available, including
7 the free acid, potassium, sodium, calcium and calcium
8 benzoyl salts as well as a resin-absorbed form.
9 It is often necessary to change the particular prepara-
10 tion of PAS in order to control digestive disturbances.
11 Allergic reactions with fever and skin rashes occur
12 uncommonly. The accepted dose of PAS is 12 grams a
13 day in three or four divided doses. The 12 grams a
14 day is administered by 24 half grams in a fairly large
15 tablet.

16 In recent years combined preparations of
17 isoniazid and PAS in suitable quantities of each in one
18 tablet, are on the market. Their chief advantage is
19 the fact that the patient cannot take isoniazid without
20 taking PAS; the disadvantage is that many of these
21 preparations cause a lot of digestive troubles.

22 The great majority of patients with tuber-
23 culosis are adequately treated with various combina-
24 tions of these three main drugs. When these drugs are
25 taken for a prolonged period of time there is an excel-
26 lent chance of complete cure in the majority of people
27 suffering from tuberculosis.

28 TREATMENT OF PATIENTS IN SANATORIA

29 It will be appreciated that with the aging
30



1 population seen now in our institutions, a great
2 variety of diseases are seen among patients and
3 these diseases often require active treatment; diabetes
4 may be singled out as it predisposes to tuberculosis.
5 Although patients enter sanatoria for the specific
6 purpose of treatment of tuberculous disease, the sana-
7 torium must be prepared at all times to treat other
8 medical conditions from which the patient may suffer or
9 which he may develop during the period of institutional
10 care. Sanatoria, therefore, in a limited way, must
11 maintain a supply of drugs beyond those which are
12 stocked and used for tuberculosis treatment only.

13 PROCUREMENT AND SUPPLY OF DRUGS FOR USE IN SANATORIA

14 With regard to drug requirements of sanatoria,
15 it has been pointed out that these extend beyond the
16 use of the anti-tuberculosis drugs since while patients
17 are hospitalized primarily for tuberculosis they do
18 suffer from conditions requiring drugs other than
19 those specifically for tuberculosis and these must be
20 procured by the individual sanatorium.

21 All physicians treating patients in sanatoria
22 are in full time institutional service and this permits
23 a considerable degree of standardization as far as the
24 types of drugs stocked and used are concerned. In
25 smaller sanatoria the medical staff considers the
26 relative merits of the various drugs available and
27 decides what drugs are to be stocked, while in the
28 larger institutions this is done by a drug committee.
29 The manner of purchasing, whether it be from a
30



1 particular manufacturer, by brand name or by generic
2 name, is decided in the same way. Drugs are purchased
3 where possible by generic name, the pharmacist
4 contacting the various firms from which the drugs
5 can be obtained for prices. Drugs used in sanatoria
6 are prescribed by the physician, the drug being drawn
7 from stock and dispatched to the ward by the pharmacist
8 or in the case of smaller institutions, the nurse in
9 charge of the pharmacy.

10 Sanatoria have limited means of testing drugs
11 for quality, etc. and reliance must be placed upon
12 quality controls maintained by the manufacturers.
13 Suppliers are aware that sanatoria do not carry large
14 inventories of drugs and that prompt service is
15 essential.



1 Up to the present time it has not been
2 possible to establish a satisfactory sanatorium formulary
3 in view of the fact that developments in drugs used
4 specifically for the treatment of tuberculosis have
5 changed and are changing so rapidly. In spite of this,
6 however, it is the present belief of most superintendents
7 of sanatoria in this province that a basic formulary
8 would be of assistance and attention is presently being
9 given to this problem.

10 Certain antimicrobial drugs used in the
11 treatment of tuberculosis are purchased by the Ontario
12 Department of Health and supplied free of charge to sanatoria.
13 the therapeutic and other qualities of these drugs having
14 been assessed by the Director of the Division of
15 Tuberculosis Prevention in consultation with certain of
16 the medical staff. When a decision to supply a
17 particular drug is made, the drug is requisitioned
18 through the Department of Health Purchasing Division
19 where it is procured in a manner similar to what has been
20 described as the procedure used in obtaining drugs for use
21 in hospitals administered by the Department of Health.

22 MR. BOYER: Mr. Chairman, the drugs that are
23 supplied by the Department of Health, does that include
24 P. A. S.?

25 DR. GRZYBOWSKI: It does include streptomycin,
26 P.A.S.

27 MR. BOYER: I understood that some years ago
28 when these were first introduced into the treatment of
29 tuberculosis, that they were quite expensive. I wonder
30



1
2 if you can say whether there has been ever any difference
3 in the price?

4 DR. GRZYBOWSKI: Yes, the drugs are much
5 less expensive. They are very reasonable at the
6 moment. The Department pays for streptomycin 16.5
7 cents per gram, about a dollar a month, just over a
8 dollar. P.A.S. is 2.20 per thousand and I.N.H. is
9 97 cents per thousand. The average cost of treatment
10 of a patient with I.N.H. and P.A.S., the cost for
11 drugs will be in the order of \$2.00, and with
12 streptomycin \$3.00 a month, if the drugs are purchased
13 by the Department.

14 MR. BOYER: Formerly, it was considerably
15 higher?

16 DR. GRZYBOWSKI: Very considerably higher.

17 THE CHAIRMAN: Has any consideration been
18 given in the Crime Laboratories in the Attorney-
19 General's Laboratory set-up to testing drugs for
20 quality that have been used in sanatoria?

21 DR. GRZYBOWSKI: I can't answer this question,
22 Mr. Chairman. I don't think so.

23 THE CHAIRMAN: Now, while you are with us,
24 Dr. Grzybowski, I think that the rates mentioned in
25 your brief would be a good starting point, and I wonder
26 if you could give us, or have prepared for a future
27 meeting of this Committee the consumption of all drugs
28 in sanatoria of all types, and specify individually
29 the drugs used. Would you describe any details,
30 giving a history of the prices, consumption and anything



1 else that is pertinent. If you would do that, I
2 think that will be very helpful because it is an
3 important subject.

4 DR. GRZYBOWSKI: Certainly.

5 THE CHAIRMAN: Mr. Tattle, with respect to
6 the quality presentation control, what would your
7 Department's position be with respect to the testing and
8 control of the drugs mentioned by Dr. Grzybowski?

9 MR. TATTLE: Well, at the present time no
10 policy has been made. We are devoting our time to
11 getting the organization underway for the hundreds of
12 drugs that are used in Ontario hospitals. In all
13 probability, we will proceed right through, naturally,
14 with the next group, the sanitoria drugs, when we
15 purchase and supply.

16 Now, as far as the drugs used and procured
17 by the sanitoria, they are a private body. They are
18 not operated by our Department, the same as general
19 hospitals. They have their own laboratories.

20 THE CHAIRMAN: Are there any sanitoria -

21 MR. TATTLE: No sanitoria.

22 THE CHAIRMAN: Under our jurisdiction?

23 MR. TATTLE: No, they are not among our
24 jurisdiction for administration purposes. Only drugs,
25 therefore, that we provide free of charge naturally
26 we would test those.

27 THE CHAIRMAN: If you supply the drugs free
28 of charge?

29 MR. TATTLE: As Dr. Grzybowski has said, there
30



1 are four or five drugs which we do supply free of charge.

2 MR. WHITE: Could the sanatoria purchase
3 through your Department if they wished to do so?

4 MR. TATTLE: It is possible, but they
5 operate independently, the same as a general hospital.
6 They have a Board of Management. The thirteen
7 sanatoria are independent from our Department. We
8 pay rents to them, but that is all.

9 THE CHAIRMAN: On Page 9, Mr. Tattle, I
10 don't want to be unfair in asking you about Dr.
11 Grzybowski's brief, but on Page 9, at the end he says:

12 "Certain antimicrobial drugs used in the treatment
13 of tuberculosis are purchased by the Ontario
14 Department of Health and supplied free of charge to
15 sanatoria...."

16 MR. TATTLE: Speaking of P.A.S., we do
17 provide them free of charge.

18 THE CHAIRMAN: What is the general authority
19 for the provision of free drugs to the sanatoria?

20 MR. TATTLE: What is the provision?

21 THE CHAIRMAN: What is the authority for
22 that?

23 MR. TATTLE: There is no authority in the
24 Statutes.

25 THE CHAIRMAN: I mean, is it a policy?

26 MR. TATTLE: It is our Department's policy.
27 This started back in 1948 when the new drugs came out.
28 The Department decided to provide the sanatoria with the
29 drugs. We were able to procure it in larger quantities
30



1 and distribute them to the sanatoria and they would not
2 cost so much.

3 THE CHAIRMAN: Well, I will continue reading:
4 "...the therapeutic and other qualities of these
5 drugs having been assessed by the Director of the
6 Division of Tuberculosis Prevention in consultation
7 with certain of the medical staff."

8 MR. TATTLE: That is right.

9 THE CHAIRMAN: Is that the director of the
10 Tuberculosis Prevention on our Ontario staff?

11 MR. TATTLE: That is the Ontario Director of
12 Tuberculosis Prevention. The selection there is made
13 in the case of this P.S.A., for example, the sanatoria
14 wanted it, the Department agreed to provide it,
15 assessed the value of it and in consultation with the
16 medical staff, decided to provide it free of charge.
17 It became government policy to do so, and we so
18 provided.

19 THE CHAIRMAN: Well then, in the last
20 sentence, he goes on to say:

21 "When a decision to supply a particular drug is
22 made, the drug is requisitioned through the
23 Department of Health Purchasing Division where it
24 is procured in a manner similar to what has been
25 described as the procedure used in obtaining drugs
26 for use in hospitals administered by the Department
27 of Health."

28 MR. TATTLE: The normal procedure is with
29 the Department of Health, quantities are determined
30



1 what they require for the sanatoria, a quotation or
2 a requisition is sent to those interested suppliers on
3 a competitive basis.

4 THE CHAIRMAN: Your Department does it?

5 MR. TATTLE: We do it, and we ship it, and
6 the invoices are received by the sanatoria and we pay it.

7 THE CHAIRMAN: Mr. Tattle, you heard my
8 request to Dr. Grzybowski about the cost of these drugs,
9 and I think in the light of what the situation is,
10 under the circumstances, I would be grateful if your
11 Department would assist him in preparing those figures.

12 MR. TATTLE: Well, the figures we are in
13 the process of preparing are figures for the Ontario
14 Hospitals and I will also include the figures for the
15 free drugs that are provided.

16 Now the date that you mentioned in so far as
17 the consumption at these sanatoria levels, that is
18 underway too.

19 THE CHAIRMAN: Are these sanatoria, Mr.
20 Fleming, members of the Ontario Hospital Association?

21 MR. TATTLE: No.

22 MR. FLEMING: They are.

23 THE CHAIRMAN: We haven't had much conversation
24 with you yet, Mr. Fleming.

25 MR. BRYDEN: Could I ask several questions on
26 the general matter? Just referring to some of the
27 general purchasing policies, Mr. Tattle, first of all
28 when you receive quotes for the supply of a certain drug,
29 does the situation ever occur or often occur where
30



1 different suppliers will supply the same drug, or offer
2 the same drug under different brand names? Is that a
3 common situation, or is it just a case of one brand
4 name as against various suppliers of the drug under the
5 generic name?
6

7 MR. TATTLE: We go out for a quotation, we
8 are going out and asking for specific drugs. It is
9 the generic name.

10 MR. BRYDEN: You call for the generic name?

11 MR. TATTLE: You have before you, Mr. Bryden,
12 a list of commodity sheets. That shows the type of
13 drug that we have grouped into groups 1, 2, 3 and 4,
14 that we mention in the brief, and those are actual
15 names of the drug. That is, we go out and ask for
16 that particular named drug.

17 MR. BRYDEN: So you are referring to the
18 generic name and all companies supply or bid on that
19 particular name?

20 MR. TATTLE: They might bid on their trade
21 name, providing it is this generic name. Although
22 they bid on the generic name, they might supply it to
23 the general public under a trade name. A good example,
24 we would go out and ask for so many millions of A.S.A.
25 tablets, A.T.C. tablets. Now Frosst is the A.T.C.
26 tablets. It is a Frosst 222. We go out under the
27 A.T.C. name, which is the generic name of it, but
28 Frosst even invoices us under Frosst's 222. We buy it
29 under the generic name.

30 MR. BRYDEN: What is your policy, to always



1 ask for quotations under the generic name?

2 MR. TATTLE: That is correct, but there are
3 people in quoting that say Frosst 222 tablets because
4 that is the product, that is their name.
5

6 MR. WHITE: Mr. Chairman, I am not just
7 clear on this last paragraph. Do I understand that
8 the sanatoria simply requisition drugs from the
9 Department if those drugs are provided free?

10 MR. TATTLE: If the drug is one which the
11 Department provides free of charge, the quantities are
12 determined by the Tuberculosis Prevention Division,
13 naturally in consultation with the sanatoria, is turned
14 over to the Department of Health. It goes through the
15 same procedures.

16 MR. WHITE: You don't maintain any stock?

17 MR. TATTLE: We had a quotation.

18 MR. WHITE: You ship direct to the sanatoria?

19 MR. TATTLE: That is correct.

20 MR. WHITE: Are they grouped for purchasing
21 to take advantage of quantity prices?

22 MR. TATTLE: Yes, that is the purpose, and
23 we would go out and ask the company for several millions
24 of tablets and when the orders are issued, they are
25 issued for seventeen Ontario hospitals. We buy them
26 F.O.B. destination, not F.O.B. Toronto.

27 MR. WHITE: That is all.

28 THE CHAIRMAN: Mr. Fleming, bearing in mind
29 that your association has some 230 members across the
30 province, does your group propose to correlate the total



1 cost of drugs used in hospitals across Ontario?

2 MR. FLEMING: Well I think that that would
3 prove a physically impossible task because we cover a
4 tremendous range.

5 I think that the Committee from what it has
6 heard today, that even in the case of one or two drugs,
7 and the use of those drugs, and the variety of uses
8 in considering costs, and particularly the factors that
9 enter into costs, to get any particular result and to
10 deal with everything, would be impossible. What do
11 you want us to run down?
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1 THE CHAIRMAN: I suppose that the infor-
2 mation I am asking about would have to be secured by
3 a carefully prepared questionnaire to be sent out.

4 With the very great experience of your
5 clients, I wondered if you might consider giving
6 some thought as to the type of questionnaire that the
7 Committee might adopt if we decided to get that
8 information. I would consider it a favour if you
9 would do that.

10 MR. FLEMING: We would.

11 THE CHAIRMAN: Gentlemen, that is the
12 agenda for today. Tomorrow morning, the Committee
13 will sit in executive session and will resume its
14 public hearings at two o'clock in this room tomorrow,
15 at which time we will hear from the Medical Association,
16 from Dr. Bryan of London. I believe he will give us
17 a statement.

18 I believe, Mr. Gadsby, that tomorrow is
19 the date set for hearing from the Ontario Hospital
20 Services Commission, through its Chairman, Dr. Urquhart,
21 who will be heard then.

22 The remaining paper by way of background,
23 as we see it at the moment, will come from the
24 Ontario Hospital Association on Thursday. We will
25 now adjourn until tomorrow.

26
27 ---Adjournment.
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R. Bryden

Select Committee on Drugs

HEARINGS

HELD AT
PARLIAMENT BUILDINGS
TORONTO ONTARIO

VOLUME No.:
2

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SELECT COMMITTEE ON DRUGS

Proceedings of hearings
held at Parliament Buildings,
Toronto, Ontario, on Wednesday,
the 15th day of June, 1960,
at 2.00 p.m.

PRESENT:

MR. H. L. ROWNTREE, Q.C., Chairman

MR. A. WREN

MR. J. A. FULLERTON

MR. J. TROTTER

MR. R. E. SUTTON

MR. R. J. BOYER

MR. N. WHITNEY

MR. H. J. PRICE

MR. K. BRYDEN

MR. J. WHITE



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TORONTO, ONTARIO

E R R A T A

To the list of Members present shown on Page 1
of the hearing of June 14, 1960, should be
added the name of MR. JOHN WHITE.



Tuesday,
June 15, 1960.

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--- On resuming at 2:00 p.m.

THE CHAIRMAN: I would like to make an observation with respect to the transcript of evidence which the reporters are taking. We have had a number of inquiries to the Secretary, and I think I should inform you that we as a Committee are not in the business of selling transcripts or connected with that organization in any way. Messrs. Angus, Stonehouse & Company Limited are taking the transcript, and anyone who is interested should direct their inquiry as to price and delivery dates, and so on, to them and I imagine, with the rotation of reporters coming in and out, that if there was one of them that you wanted to speak to, you would not have any difficulty establishing some liaison.

Now, this afternoon we are going to hear a statement from the Ontario Medical Association and also, a statement from the Ontario Hospital Services Commission. I don't want to delay this unduly, but before I call on anyone, I would like to wait until Dr. Urquhart comes down. He has gone to get some extra copies of the Hospital Services Commission brief, and if you would just be patient for two or three minutes, we will be pready to proceed.

We will now proceed, and I will ask Dr. Brien to come forward.

---(Dr. Brien comes forward)



1 THE CHAIRMAN: Dr. Brien, would you identify
2 your situation with respect to the Ontario Medical
3 Association?

4 DR. E. S. BRIEN: Mr. Chairman, I am the
5 Chairman of the Pharmacy Committee of the Ontario
6 Medical Association, and in that capacity was asked to
7 appear before you today and present this brief on behalf
8 of the Association.

9 THE CHAIRMAN: Shall we proceed then with
10 your submission?

11 DR. BRIEN:
12 "This Brief is submitted on behalf of the members
13 of the Ontario Medical Association, who are the
14 principal prescribers of the drugs provided for
15 the treatment of patients in the public, general,
16 and provincial mental hospitals, and sanatoria of
17 the Province of Ontario, by the Ontario Hospital
18 Services Commission.

19 It is the firm belief of this Association that
20 all of the doctors of the province should have
21 available to them drugs of known potency, the use
22 of which will likely result in benefit, and do no
23 harm, to patients so treated, in any of the
24 institutions mentioned in the preceding paragraph.

25 It is the desire of the Association that this
26 privilege should be used with intelligence, care,
27 and common sense, and be not abused. It is
28 further the conviction of the Association that,
29 when feasible, less costly, rather than more costly,
30



1 pharmaceutical preparations should be, and, in the
2 main, have been, used in the treatment of patients
3 with coverage for hospitalization under the Ontario
4 Hospital Services Commission."

5 This concludes the brief as it has been typed.

6 Prior to luncheon today, I had a moment to
7 speak to Dr. Urquhart and, with your permission, sir,
8 I would just like to amplify the last paragraph a little
9 bit.

10 THE CHAIRMAN: Yes.

11 DR. BRIEN: And it is to this extent: The
12 statement should be more inclusive than it now is,
13 because if there be patients in hospitals whose care is
14 not covered by the O.H.S.C. Plan, then the charges that
15 are levied against them are in conformity with the
16 charges that would have been paid by the Commission had
17 they been so insured, and, therefore, this statement
18 should be a little broader. Thank you.

19 THE CHAIRMAN: I gather, from part of this
20 submission, that you are dealing obliquely with what
21 I understand to be the right-to-prescribe theory which,
22 I would expect, is something that would be jealously
23 guarded by the medical profession. Would you have
24 anything to say on that point?

25 DR. BRIEN: Yes, I would, sir. When the
26 plans were formulated by the Commission, with respect
27 to all aspects of hospital coverage, the then members
28 of the Commission communicated with the Ontario Medical
29 Association to ascertain its views relative to a number
30



1 of problems, I think, and in particular, with
2 respect to the provision of drugs.

3 This matter was referred to the Pharmacy
4 Committee of the Association and it had the same
5 Chairman then as it does now, and in the early part of
6 1958, a series of meetings was held at which what seemed
7 to be reasonable and proper methods for the prescribing
8 of drugs was set forth by the Association. It was set
9 forth at first by the Committee and then, approved by
10 the Council, which is the governing body of the
11 Association, and those, I think, are in very large
12 measure, with little or no alteration, were drafted
13 into the regulations of the Commission as they now
14 stand, and in their simplest terms they can be reduced
15 to this: That the Doctor should have the right to
16 prescribe whatever drugs that were approved in the sense
17 that they were known to be potent and were in keeping
18 with clinical usage that was acceptable; that he should
19 have the right to prescribe whatever of those were
20 necessary for the benefit of the patient he was treating.
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1 THE CHAIRMAN: I suppose that resolution or
2 declaration took the form of a set of guiding principles
3 or was it made effective in the Medical Association or
4 in the College of Physicians and Surgeons by regula-
5 tion?

6 DR. BRIEN: The College of Physicians and
7 Surgeons has had, I think, no part to play in these
8 arrangements at all. They have rested today, I think,
9 only between the Commission and the Association and
10 they are well-known to the members of the Medical
11 Association as I am sure they are to the members of the
12 Commission.

13 THE CHAIRMAN: Could that statement be
14 made available for the Committee?

15 DR. BRIEN: Yes, it certainly could.

16 THE CHAIRMAN: Is there any other prin-
17 ciple that is set forth with respect to your profession
18 which covers beyond those patients covered by the
19 insurance scheme?

20 DR. BRIEN: The only point in this respect,
21 and I may not just understand clearly your question,
22 sir, the charges to a patient who, for instance, had
23 to pay the costs of this hospitalization out of his
24 own pocket would be exactly the same, and this is the
25 point Dr. Urquhart was making to me before lunch
26 today, that would be exactly the same as if they had
27 been paid by the Commission, and therefore there
28 would be no difference in prescribing for an insured
29 or non-insured patient on the basis of what it would
30 cost.



1 THE CHAIRMAN: So that you are suggesting
2 in either case the total drug bill would not be
3 affected?

4 DR. BRIEN: No.

5 THE CHAIRMAN: Doctor, would you care to
6 comment, I might say at this point to you that this
7 part, this first part of this Committee's hearings are
8 directed to background information, the Committee being
9 composed of laymen and we are endeavouring to get some
10 broad information to enable us to proceed into more
11 specific avenues at a later date. Would you have any
12 comments on the subject of prescriptions by trade or
13 generic names?

14 DR. BRIEN: This is, of course, a very
15 interesting and much discussed point. As a teacher
16 concerned vitally with therapeutics, or the teaching of
17 how to use drugs, I have had to face this problem for
18 years.

19 A lot has been said pro and con as to whether
20 a drug will cost more or less depending on whether it
21 is a particular trade name, or if the generic name
22 only is used.

23 As a doctor and as a teacher, the thing I am
24 vitally interested in is primarily not cost, and I do
25 not wish, sir, to give you the impression that I am
26 tossing that subject aside at all because it is a very
27 real one, as you know. The matter that I am vitally
28 interested in is that when a prescription is written,
29 whether it be in a hospital, be filled in a hospital
30

1 pharmacy or be taken to a neighbourhood drugstore, or
2 indeed dispensed by a doctor from his own little
3 pharmacy, that he can rely on material being what it
4 purports to be, and I think that is the most important
5 thing of all, sir.

6 THE CHAIRMAN: Let's then for a moment
7 apply that to the time, and the point when the pres-
8 cription is being written. Would there be some
9 drugs sold under generic name that would be acceptable,
10 and others not?

11 DR. BRIEN: I am in no position to answer
12 that question either very intelligently, or indeed
13 truthfully because I am not in possession of the facts
14 on which such an answer would depend.

15 It obviously must be the responsibility of
16 some body to ensure that drugs or pharmaceutical
17 preparations, whatever you wish to call them, should
18 have an acceptable standard of purity or quantity,
19 however you want to measure it. In other words, in
20 exactly the same way that you give specifications within
21 which piston rings, cylinders may fit and be acceptable,
22 the same must apply to drugs.

23 I suspect that it is very difficult to measure
24 drugs to an infinite fine degree, but I think it should
25 not be too difficult to see that they fall between
26 acceptable limits, and I think that is the thing I am
27 concerned with in answering your question; but I am
28 not too perturbed about whether a substance is prescribed
29 under a generic or a trade name.
30



1 As a matter of fact, for many years I have
2 done a mixture of both as a personally practising
3 physician, and the reason that I did this was that in
4 certain aspects of medicine, one becomes very familiar
5 with the precise expected action that one will obtain
6 from one drug or another. I think we tend to fall
7 into habits sometimes, but I wouldn't be too worried
8 about trade name versus generic name provided I was
9 satisfied that the controls are adequate, and I am in
10 no position to talk about many of those things, as you
11 might well expect, sir.

12 THE CHAIRMAN: The controls being adequate,
13 I take it we are talking about such things as purity?

14 DR. BRIEN: That is right, and strength.
15 That it is pure and it is what it says on the label,
16 and nothing else.

17 THE CHAIRMAN: I presume that in your
18 experience you feel that some items seem to suit your
19 purpose better and so you ---

20 DR. BRIEN: I would deliberately prescribe
21 some by a trade name, or brand name, and others by a
22 generic term and I suspect that most practising
23 physicians do the same.

24 THE CHAIRMAN: Doctor, would you be in a
25 position to assist us in telling us the extent to
26 which medical practitioners make up their own pres-
27 criptions in this province?

28 DR. BRIEN: I am afraid that I can't give you
29 anything accurate in this regard. Certainly it is a
30



1 much less prevalent custom than 25 years ago, and very
2 much less prevalent than it was 50 years ago.

3
4 The habits of doctors in this regard has
5 varied a great deal, as much as anything I think on a
6 geographic basis. I come from a family that has
7 produced seven doctors, and they practise, six of them
8 in Canada and one in the States in widely separated
9 areas, and their habits with respect to the question
10 that you directed to me are completely different.
11 Also, there is a tendency, I think, in the larger
12 urban centres, as a general thing, for much more
13 prescribing with respect to the pharmacists or the
14 pharmacy than in the smaller areas.

15 This is still true, but I can't give you
16 percentage-wise an answer that would be very worthwhile
17 except that doctors are gradually doing less and less
18 dispensing and more and more prescribing.

19 THE CHAIRMAN: I would think that the factor
20 would have a direct relationship to the location, or the
21 area where the doctor is practising and the convenience
22 or availability of hospital accommodation and the
23 supply of drugs and merchandising outlets.

24 DR. BRIEN: That is the point. As we now
25 operate in hospitals, certainly people who are covered
26 by any of the available methods of getting coverage,
27 as soon as they leave hospital, they must provide their
28 own drugs.

29 Prior to the institution of the OHSC plan,
30 it was not an uncommon practice, I am sure, in a number



1 of hospitals, I can't say how many, for patients to
2 take home with them certain amounts of medication that
3 actually they obtained in hospital and that varied with
4 the type of trouble they had. They must either get it
5 from a doctor, or a pharmacy and it might be a hospital
6 pharmacy.

7 THE CHAIRMAN: Doctor, you might be able to
8 assist us on this point, but we are interested in the
9 extent to which the dental profession prescribes drugs,
10 and without attempting to embarrass you with another
11 profession, let me say this, that it is my understanding
12 that apart from the drugs which are used by the dental
13 profession in their day to day treatment of patients,
14 in their office, that the actual prescription of drugs
15 and I believe it is correct that they have a right to
16 write a prescription?

17 DR. BRIEN: Yes, they do.

18 THE CHAIRMAN: Do you think that that factor
19 is a major factor in the consumption of drugs, or is it
20 in today's life generally referred to the patient's
21 physician?

22 DR. BRIEN: I would think that a percentage
23 of drugs prescribed by dentists is an extremely small
24 fraction of the total amount of drugs used. Yes, it
25 is a very small fraction.

26 THE CHAIRMAN: I am asking this as much to
27 eliminate the point as to get information.

28 DR. BRIEN: You see, you may or not be
29 conversant with this point as far as hospitals are
30



1 concerned: a patient may be admitted for dental care
2 only under a physician who must assume the responsibility
3 for the care provided by the dentist, although the
4 dentist may write his own orders, and there are certain
5 restrictions relative to certain requirements that must
6 be fulfilled in order for a patient to be admitted for
7 dental work in a hospital. A great deal of it doesn't
8 need to be done in hospital.
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THE CHAIRMAN:

1 Earlier you said that your doctor's first concern in
2 writing a prescription would have to do with the knowledge
3 or reliability or purity that was the general area of
4 the product?

5 DR. BRIEN: Yes.

6 THE CHAIRMAN: Are practicing doctors
7 familiar with the prices at which the drugs are sold?

8 DR. BRIEN: I would certainly think that
9 most of them are quite well informed on this point,
10 particularly by some of their patients. We all know
11 that some medications are quite expensive. There is
12 no argument about that at all.

13 However, the use of this may be extremely
14 worth while, and it might be very much to the benefit
15 of not only the patient, but the chemist too, sometimes,
16 when more expensive, rather than less expensive drugs
17 are used for this reason: That in the case of Victoria
18 Hospital where I practice in London, our 1959 cost of
19 drugs per day, if my informant is correct, the
20 superintendent of the hospital, in 1958 it was 98 cents
21 per day per patient. In 1959, under the first year
22 of operation of the scheme, it was \$1.12. In other
23 words, it went up roughly 14 percent.

24 Now it might be, there are times when it is
25 decidedly better to increase the drug bill and reduce
26 the per diem grant, which is in our case, say somewhere
27 between \$18.50 and \$19.00, something in that order.
28 So that is part of the reason for my construction here,
29 in which I say that when feasible to use a less costly,
30



1 rather than a more costly drug. But also, care and
2 common sense should be used, taking the whole picture
3 into account.

4 I might say, as a doctor who is visited
5 probably as much and maybe more than most by some of
6 my friends here from the pharmaceutical houses, that I
7 am abundantly aware of what the agents they purvey cost.
8 I am perfectly sure that that is common practice.

9 THE CHAIRMAN: That is a very interesting
10 point that you raised with respect to the drugs being
11 administered at a somewhat higher cost than might other-
12 wise exist, having to do with one and the same patient.

13 DR. BRIEN: Yes.

14 THE CHAIRMAN: And the possible economic
15 savings which would result in other avenues.

16 DR. BRIEN: Yes. I think that there are
17 multiple factors involved in disease, and the way it
18 affects people, and there are now many therapeutic
19 approaches to a lot of problems. There are multiple
20 approaches in many instances. One of the most important
21 thing that help doctors, I think, is that in many
22 instances the patient has a disease which in the passage
23 of time will work out.

24 THE CHAIRMAN: They will recover?

25 DR. BRIEN: Yes, in a great many instances,
26 the people would recover on their own resources. You
27 may be able to cut that recovery period down very
28 markedly by the use of either some of our older thera-
29 peutic friends, or even still more - and this is where
30



1 the point comes in - by the judicious selection of
2 some of the more costly presently available agents.
3 I think that a great deal of experience, care, and
4 common sense tells you what to do.

5 THE CHAIRMAN: Is it possible, Dr. Brien,
6 to state in a broad sense in what general categories the
7 most expensive drugs lie?

8 DR. BRIEN: Yes. I won't attempt to name
9 them all, but the steroid hormones are relatively
10 expensive, very much less so now than when cortisone
11 first appeared, but still, nonetheless, very expensive
12 when compared with agents such as aspirin.

13 Antibiotics, of which there is now a large
14 range, vary, very considerably in their cost. Some
15 of them are very expensive.

16 Two nights ago, I met a young lady in the
17 hospital corridor who had a bottle of the germs that
18 occur in boils circulating in the blood stream. This
19 is a most hazardous disease for anybody to harbor, and
20 unfortunately, it is one which requires sometimes,
21 multiple forms of therapy, and in some instances, is
22 untouched by them, no matter how extensively or
23 expensive. This young woman is perfectly well. I
24 hesitate to think what her drug bill would have been,
25 and the Commission is in exactly the same position. It
26 would have been a disaster for this patient. She
27 would have succumbed without it.

28 I am not in the least perturbed about the
29 justifiable use of expensive agents when faced with a
30



1 lethal condition or potentially lethal one in which
2 there is a reasonable hope of success, and that was a
3 case in point.

4 I would be much concerned about the unjustified
5 use of penicillin and other agents that a lot of you are
6 familiar with for trivial complaints, because they are
7 apt to do no good in the first place, and what is worse,
8 they might set up a state of hyper-sensitivity in you,
9 so that when you do become afflicted with something that
10 really matters, you would react adversely to the
11 properly prescribed medicine. So there are many
12 facets to this problem.

13 There are other hormones in the steroids that
14 I would say generally fall into what might be called an
15 expensive class. Their use, properly undertaken, is
16 in a relatively narrow field. They are not nearly as
17 widely used, for instance, as antibiotics.

18 There are certain other agents that are not
19 antibiotics and antibiotic is a by-product of something
20 living. In the case of penicillin, it is a mold, and
21 as it grows, its mold penicillium which is its by-
22 product, produces a substance of which penicillin has
23 a large variety.

24 Now there are other substances so obtained,
25 which are not really antibiotic. There are other
26 antibacterial or antigerm medications. I think you
27 would perhaps more properly call them "chemicals" of
28 one sort or another that are made by chemists, that
29 come into this category, too, and which have a completely
30



1 justifiable sprectrum in which they might be used, but
2 again, tolerably narrow. They should not be used
3 indiscriminately.

4 THE CHAIRMAN: Could you assist us with the
5 names of any periodicals which exist on a professional
6 basis, which can use our information about new
7 developments on drugs which have been accepted and
8 proven and which are on a non-advertising basis?

9 DR. BRIEN: Well, most drug advertisements,
10 to use the term loosely, are carried out in the pages
11 of professional journals as they relate to medicine
12 and surgery. I suspect the same occurs in relation
13 to dentistry, and I am not sure about the veterinarians,
14 but I suspect that they have theirs too.

15 This is a relatively restricted field. It is
16 not in the daily newspaper, in the daily press or in
17 lay publications.

18 Our own Canadian Medical Association Journal,
19 the Ontario Medical Review, which is a provincial
20 division publication of the O.M.A., certainly carries
21 both legitimate advertising and comments that are
22 written relative to surveys on drugs that have newly
23 come on the market, and the place that they are apt to
24 play in medicine. That information is not hard to get,
25 sir.

26 THE CHAIRMAN: In some of these professional
27 journals, there are editorial comments which is not in
28 the form of paid advertising?

29 DR. BRIEN: Oh, no. Then there are
30



1 publications that are directed more at therapy than the
2 use of drugs, amongst other things, in the treatment
3 of disease.

4 There are publications that deal, not
5 exclusively, but almost exclusively, with this sort of
6 thing. But it is quite easy to get information that
7 is not put out by paid advertising.
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1 MR. BRYDEN: What are some of these
2 publications you were referring to, Dr. Brien? Could
3 you give us some of the titles of the publications
4 that I think you described as being directed to therapy?

5 DR. BRIEN: Well, one is called "Current
6 Therapy". That is a textbook which comes out every
7 year and selected authors deal with a wide variety of
8 subjects from the standpoint of treatment, not alone
9 drugs but in combination with other things. There is
10 a yearbook of drug therapy that carries some very good
11 reviews of medication as used all over the English-
12 speaking world and perhaps further together with
13 comments by one of the best known therapists in the
14 United States.

15 MR. BRYDEN: Those are American publications?

16 DR. BRIEN: Yes, those two are. I would
17 think the pharmacologists have journals of their own
18 that go right down to the very basic background of many
19 of these things and which the average doctor, unless
20 he is part of the pharmacology department or a member
21 of a school of pharmacy would not ordinarily use.

22 THE CHAIRMAN: Are all pharmaceuticals --
23 is it "fahrmuhsuetickal" or "pharmakewtical"?

24 DR. BRIEN: Well, in the part of Ontario
25 I live in it is known as "fahrmuhsuetickal".

26 MR. WHITE: That is a good part of the
27 country.

28 THE CHAIRMAN: What is the relationship
29 between a pharmaceutical and a chemical?
30

1 DR. BRIEN: Well, sulphuric acid is a
2 chemical that I would hesitate to use as a pharmaceutical
3 agent. Hydrochloric acid, on the other hand, is a
4 chemical that our fathers, who were doctors, prescribed
5 for patients for years. Chemical substances may bear
6 no relation to pharmacy and, indeed, many of them are
7 highly toxic. Chemistry is an all-embracing term that
8 covers many things that are never thought of in terms of
9 a pharmacy or a pharmacist who is really a purveyor, at
10 one level or another, of agents that are used in the
11 treatment of disease -- treatment or prevention of it,
12 I think would be correct.

13 THE CHAIRMAN: I suppose I might say that the
14 chemistry of the body sometimes requires the assistance
15 of pharmaceuticals.

16 DR. BRIEN: It certainly does, sir.

17 THE CHAIRMAN: Gentlemen, have you any
18 questions you care to ask?

19 MR. WHITE: Mr. Chairman, without opening
20 up any new ground, may I clear up one or two things
21 that Dr. Brien said. Dr. Brien, you made the point
22 that there is -- in addition to your printed brief --
23 when a doctor prescribes for a patient the cost of
24 that drug may be the same whether it is paid through
25 the Ontario Hospital Services Commission or presumably
26 through some other source. Perhaps I am misunderstanding?

27 DR. BRIEN: Perhaps this was a point that I
28 discussed with Dr. Urquhart and he may very well allude
29 to it himself when he speaks to you. If, for instance,
30



1 you came to Victoria Hospital and did not have the
2 benefit of coverage by the Ontario Hospital Services
3 Commission and had to pay the bill from your own
4 pocket, you would be charged exactly the same. In
5 other words, the hospital would take in precisely
6 the same moneys from you that it would get from the
7 Hospital Services Commission. That is, the basic
8 costs of hospitalization which are what is included
9 is now the basis on which charges would be made and
10 that charge would be the same to you whether you received
11 a lot of medication or none at all. In other words,
12 it is not on the old basis of so much for your bed and
13 board and additional items covering the cost of the
14 drugs.

15 MR. WHITE: But let us assume a patient
16 is not covered by the Ontario scheme, he would be charged
17 for the drugs actually used; is that correct?

18 DR. BRIEN: No.

19 MR. WHITE: There is a per diem charge?

20 DR. BRIEN: He would have an overall per
21 diem charge which actually is not the same, it varies
22 from hospital to hospital for many reasons.

23 MR. WHITE: What you say is true of Victoria
24 Hospital. Would it be true in all the general
25 hospitals in Ontario?

26 DR. BRIEN: It would be true in every hospital
27 that is approved by the Hospital Services Commission
28 as a place to which you or I might be admitted and for
29 which they would pay the per diem rate if we were so
30



1 insured.

2 MR. WHITE: Thank you. Now then, you said
3 shortly afterwards that somebody must be responsible for
4 assurance that drugs and pharmaceuticals preparations
5 meet certain minimum quality specifications. Is there
6 such a body now in Ontario?

7 DR. BRIEN: There is one in Canada which has
8 the responsibility, I would think -- the Federal Drug
9 and -- I am sorry, I cannot give you the precise name
10 for this, but it is a branch ---

11 THE CHAIRMAN: The Food and Drugs Act?

12 DR. BRIEN: Yes, I think it comes under that.

13 MR. WHITE: I asked the question because we
14 were informed yesterday, and I am quoting from a brief
15 from the Attorney-General's Laboratory:

16 "Some companies do not have an adequate control
17 "organization and in such cases, the testing done
18 "in the Attorney-General's Laboratory is an essential
19 "safeguard."

20 This is for drugs obtained for the Government
21 only.

22 DR. BRIEN: Yes.

23 MR. WHITE: Is the testing done in the
24 Attorney-General's Laboratories an essential safeguard?
25 I mean, the inference there is that there is not such
26 a body as you said is necessary.

27 DR. BRIEN: I think that a great majority of
28 manufacturers of drugs have pretty carefully built in
29 controls of their own and I would be reasonably certain
30



1 that certainly the larger firms would have. I would
2 not want to belittle the smaller ones merely on the
3 basis of size. I think a great deal depends perhaps
4 on the nature of the material that you are manufacturing.
5 There are times when these are less strong -- pernicious
6 anemia which most of you will realize is a form of
7 anemia that was fatal in many instances prior to the
8 discovery of liver extract and liver extract was sub-
9 sequently replaced by Vitamin B12. At one stage in the
10 development of this therapy which commenced back in the
11 early 1920's -- 1922 or '23 -- the only way one could
12 tell whether the liver extract was potent or not was to
13 give it to somebody with pernicious anemia and see if
14 they improved. In other words, that was the method of
15 biologically testing it. I am not saying that not all
16 batches were potent. I can remember as a house doctor
17 when I saw the effects of some that was not potent.

18 MR. WHITE: I do not want to misquote you,
19 but would it be fair to say that if there is not such a
20 body in existence now checking the quality of these
21 drugs, then there should be.

22 DR. BRIEN: I would have no hesitation in
23 saying that would be a sound thing or the present one
24 should be extended if it is not able to do it.

25 MR. WHITE: Now, getting down to trade names
26 versus generic names: if a doctor prescribed a drug
27 by its generic name you do not know what manufacturer's
28 product would be supplied. Would it be true that you
29 might or might not get a good quality, assuming this
30



1 information is correct?

2 DR. BRIEN: Well, if I write a prescription
3 in which I specify so-and-so brand of this-or-that, I
4 would likely do that because I was very happy with the
5 use of that drug. If, on the other hand, I wrote down
6 a generic name for whatever it was, depending on what
7 the substance was, the pharmacist may have 20 choices --
8 he could have six of them sitting side by side on his
9 shelf and it would be his decision then, which bottle
10 he would take it from.

11 MR. WHITE: I have been told that the
12 ethics of the profession require him to supply the
13 cheapest.

14 DR. BRIEN: Well, I cannot answer for that
15 because I do not belong to the ORPA and just do not
16 know. I am not sure the price alone has to do with
17 quality.

18 MR. WHITE: Well now, Doctor, just a couple
19 more brief questions. You mentioned in reply to your
20 question from the Chairman that you thought doctors
21 would know quite a bit about drug costs and that does
22 not add up with some of the information given to me by
23 some of your colleagues in London who have made it a
24 point to tell me that they usually do not know how much
25 the drug costs that they prescribe and are often
26 surprised to find out later from the patient that the
27 drug is a very expensive one.

28 DR. BRIEN: I can tell you precisely why
29 they do not know; very simply, they do not talk to the
30



1 detail man from the pharmaceutical house, they let their
2 secretary do that or for one reason or another, there
3 are legitimate reasons, they do not talk to them them-
4 selves. I, almost invariably, am told what the cost
5 of agents will be and I suspect that these gentlemen
6 who spoke to you and who are undoubtedly well-known to
7 me, just ask them how many times they talk to the
8 detail man. I think that many times I do it it is a
9 thankless job, but I think that a detail man, pharma-
10 ceutical house, really earns his money, he has got to
11 work hard.

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1
2 MR. WHITE: Do you say it is part of a
3 doctor's responsibility to know the cost of a drug he
4 is prescribing?

5 DR. BRIEN: Yes, I do. May I take a
6 moment here.

7 This is particularly applicable outside the
8 hospital, because then it is the individual, almost
9 invariably, who is the one who pays for it. Just
10 because a scheme to which most of us contribute provides
11 him the coverage or the drugs in the hospital, is no
12 reason why we should abuse it. But the cost of
13 certain medications is quite high. I am perfectly
14 satisfied that in the interests of the best possible
15 practice of medicine, the doctor should decide, when
16 it comes to treating a particular ailment - he should
17 take multiple factors into view. The cost of medicine
18 is one. Now, let me explain this further, because
19 I think this is a critical point. The cost should
20 not become a factor that would make him fail to use an
21 essential preparation in a particular case; but there
22 are a good many instances in medicine when one has a
23 legitimate choice between aspirin, for example, which
24 costs a fraction of a cent per tablet; antibiotics,
25 which might cost anything up to 20 or 30 cents or even
26 more, depending on the situation; or steroids, which
27 basically, may cost something like 25 cents per tablet.
28 Now, a man's knowledge of the disease, how he is likely
29 to respond to half of these agents that I have mentioned
30 or any other agent, should determine what he would use



1 basically; but there are times when one has a choice
2 and you can argue back and forth by just lining them up
3 on two sides, the one that would use aspirin in a given
4 situation and the one in the others.

5 Now, in a situation like that, the cost
6 could very well and reasonably so be taken into account,
7 particularly if the higher priced item would work a
8 hardship, if it were to be carried on for long.

9 THE CHAIRMAN: Is it the shock to his system?

10 DR. BRIEN: Well, yes.

11 MR. WHITE: I just have one final question.
12 I think that you mentioned that drug cost at Victoria
13 Hospital have gone up; was it 98 to 112?

14 DR. BRIEN: Yes. There are various ways
15 of presenting this problem.

16 When the initial discussions, Mr. Chairman,
17 were underway, it was perfectly obvious to me, as the
18 Chairman of this Committee, that the costs of drugs
19 used in any hospital, any general hospital, at least,
20 covered by the plan, would rise. Some of the factors,
21 you have heard mentioned already. Now, how much
22 would be a reasonable amount for them to rise was another
23 question entirely.

24 THE CHAIRMAN: May I interrupt you for one
25 moment and ask you: When you said that it appeared
26 that the cost of drugs would rise, did you mean that the
27 total, that the actual cost of individual items would
28 increase?

29 DR. BRIEN: No. I am not referring to the
30



1 cost as manufactured. I am referring to the cost in
2 terms of either more drugs or more costly drugs being
3 prescribed in a hospital, particularly when the factor
4 of individual expense on the part of the patient was
5 removed. That is the aspect I meant. Having a
6 scheme like this behind one, must inevitably - if
7 you are a conscientious doctor, and thinking about all
8 the angles that I have discussed with you, Mr. White -
9 it must inevitably still result in a situation like this;
10 that there are times when, for the sake of argument,
11 you have someone with one of the rheumatoid conditions
12 which may get better with aspirin in time and physio,
13 or it might get better much more quickly with steroids.

14 Now, if when we are dealing in a situation
15 where - just purely as a doctor, without cost at all
16 - were weighing the merits of the case, it is obvious
17 that you might pick one or the other. If, on the
18 other hand, again, where the scales are in the balance
19 and you are dealing with someone on whom this might be
20 a hardship, it is perfectly obvious that you would use
21 aspirin.

22 MR. WHITE: That answers my question, thank
23 you, Doctor.

24 MR. SUTTON: Mr. Chairman, may I ask a
25 question?

26 THE CHAIRMAN: Yes.

27 MR. SUTTON: Dr. Brien, I thought you had
28 in your position as Chairman of the Pharmacy Committee -
29 that you had a great many calls from detail men?
30



1 DR. BRIEN: No. It is not because of my
2 position on the Pharmacy Committee at all that I get
3 called.

4 MR. SUTTON: Let us put it another way. You
5 have frequent calls from representatives of the drug
6 manufacturing companies?

7 DR. BRIEN: I certainly do.

8 MR. SUTTON: And I am wondering just to what
9 extent their presentation of their discovery influences
10 a general practitioner in prescribing the trade-name
11 drugs in preference to the generic drugs? Now, it has
12 been said that the general public is a captive market.
13 In other words, the doctor who prescribes and orders
14 the drug is not the person who pays for the drug.

15 DR. BRIEN: That is correct.

16 MR. SUTTON: Also, it has been published
17 many times that the drug industry are very generous with
18 the doctors by way of samples of high-priced drugs for
19 use, or, in your own discretion, to use and prescribe
20 to patients who are unable to pay the high cost of drugs.
21 I am just wondering if you would like to make any
22 comments on either of those two questions?

23 DR. BRIEN: I think there are two sides to
24 this question of the provision of drugs, of the higher-
25 priced ones. A certain number of people who occupy
26 a position similar to my own, which is a Professor of
27 Medicine at the University of Western Ontario -- I am
28 Chief of the Medical Service of the Victoria Hospital --
29 are often asked if they would be interested or willing to
30



1 use some of the agents which are not yet, or as yet
2 available on the open market. These might or might
3 not be very expensive. And I have been approached,
4 as I am sure every professor in medicine has, on many
5 occasions by representatives - from even the Medical
6 Director of some of the larger pharmaceutical houses,
7 to see whether I would be interested in initially using
8 in this country agents not as yet on the open market,
9 but which, from the previous work, chemical,
10 pharmacological, biological, perhaps, with respect
11 to some of the lower animals or even some of the higher
12 ones, you might feel would be reasonable, safe, as
13 safe as one could make it, to use on patients that you
14 had careful control of and which fitted into the
15 category in which it was desired that the drug be
16 investigated and this, actually, has gone on with every
17 worthwhile agent that is available to us.

18 MR. SUTTON: This is an experimental thing,
19 is it?

20 DR. BRIEN: It is not experimental. It is
21 experimental, if you wish to use it in the proper term,
22 in the proper sense. There must be a time in the
23 evolution of any drug, from the time of its manufacture
24 until it reaches the shelves of our drug stores - there
25 must be a time when somebody takes it, and the people
26 who often carry out that sort of work, who have the
27 controls that would appear to be necessary, and the
28 access to adequate number of people with the troubles
29 concerned, are usually in the larger teaching centres.
30



1 Now, that is one aspect of drugs and a very necessary
2 and important one too.

3 The other one, which is the one I am sure
4 Mr. Sutton is thinking of, and that is in the case of
5 already established drugs - ones that are more or
6 less in common use, but which are quite expensive or
7 even very expensive. You have, apparently, been
8 told that quantities of these have been placed in the
9 hands of people, with certain physicians, to dispense
10 these to at least the considered proper range of
11 conditions, to persons to whom it would work a hardship
12 if they had to pay for them.

13 Now, again, I am perfectly sure --. I
14 have access to certain drugs like that. Again, anyone
15 in my position has. The fact that in this very
16 particular geographic position in which I work, which
17 is confined to one hospital basically, the vast majority
18 of the people who come to the clinics which I supervise
19 and who fall within the old-fashioned term of "indigency",
20 which I don't need to go into; in the particular
21 situation in which I find myself, our hospital
22 pharmacy provides these, actually, in most instances,
23 but not all.

24 So that it is again, even if those people be
25 not confined to hospital beds, it is no hardship for
26 them. There is the odd person on whom it is and I
27 may say, without any fear at all, that I have approached
28 on occasion various pharmaceutical houses to provide
29 agents for these people who, in my opinion, really
30



1 needed help, and they have always been generous.

2 I mean, I am making no brief at all one way or the

3 other, other than to say that I have access to such

4 materials. I wouldn't use them without a good reason,

5 speaking of the established drugs.

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1 MR. BRYDEN: There are two questions, if you
2 wouldn't mind answering. First of all, we had been
3 discussing a little earlier, Doctor, the question of
4 information which is available to doctors in regard to
5 drugs, and you mentioned certain publications, and so
6 on. I presume that information would relate to the use
7 of a particular drug without any particular reference to
8 any specific brand name. Would that be the nature of
9 the information in those publications you referred to?
10

11 DR. BRIEN: As a matter of fact, sir, there
12 are some instances, I think yet where a single --
13 I make this with reservations now, this statement, but
14 I think that there are instances where a single firm
15 only produces a particular agent.

16 Now, they may market that under -- they have
17 no competition, nobody else is making it -- they may
18 market under a name of their own which is easier to
19 say than one of these great long complex chemical
20 formulae which is what they usually incorporate into
21 the generic name, or they may just use the generic
22 name. You will find in the literature I was men-
23 tioning both kinds.

24 MR. BRYDEN: Well, in the case -- I understand
25 your point that there are some drugs, especially new
26 ones, that are put out by only one firm.

27 DR. BRIEN: That is right.

28 MR. BRYDEN: In the case of drugs which are
29 fairly numerous, we have firms putting out the same drugs
30 under different brand names. Does the average



1 practitioner have any significant source of information
2 about the relative merits of the different brands,
3 other than the promotional literature that he gets
4 from the firms that are putting them out, and from
5 their detail men?

6 DR. BRIEN: Well, his greatest source of
7 information would be some sort of publication that
8 gave a critical review of either just the treatment
9 aspect of certain diseases, or the diagnostic treatment
10 and that is available in a variety of ways.

11 For instance, there is one publication that
12 has the name "Drugs of Choice" written by a very able
13 fellow. That is the name of the book. This is
14 published once a year and he says precisely what he
15 thinks about a whole host of things, and this is revised
16 roughly yearly.

17 MR. BRYDEN: That would compare the relative
18 merits of the same drugs?

19 DR. BRIEN: To a degree it does, but it is
20 impossible, I think, to sit down and find written down
21 anywhere a comparison of the relative merits of all
22 firms to any drugs that are available; would be quite
23 difficult to get that. It could be done piecemeal,
24 though.

25 MR. BRYDEN: I understand that there is a
26 publication that has started up in the States within the
27 last year or so called the Doctor's Letter, or the
28 Medical Letter. I am not quite sure about it, which I
29 take is designed to fill up what is conceived, at least
30



1 by those putting it out, to be a void, or a gap in the
2 information available.

3 DR. BRIEN: There are several publications
4 that are in that general category, yes.

5 MR. BRYDEN: You wouldn't know, offhand,
6 about their relative merits or anything about them?

7 DR. BRIEN: I haven't perused them enough to
8 make any statement. I am not trying to avoid answer-
9 ing it, I just haven't got enough facts in my head to
10 give you an honest opinion on that point.

11 MR. PRICE: Doctor, would you tell us
12 something of the qualifications of these so-called
13 detail men, and also whether you feel they have a use-
14 ful function in the practice of medicine?

15 DR. BRIEN: Well, I can tell you what I think
16 about detail men very, very quickly. In the first
17 place, most of them -- I hesitate to say all, I am not
18 that well informed, but certainly a good many of them
19 are pharmacists.

20 They are men who have gone through pharmacy.
21 Some of them have either worked and changed to larger
22 stores; indeed, some of them have had stores of their
23 own. Occasionally these men will work for one firm
24 and then go back to the retail side of pharmacy, and
25 then the first thing you know you meet them again
26 representing somebody else. They shift around, within
27 limits, like many professional people.

28 Most of them I think basically are fairly
29 well informed on the materials that they are detailing.
30



1 I don't know whether I get a special group sent to see
2 me or not, but once in a while they come to see me
3 about something that I know considerably more about
4 than they do, and it is very interesting; not too
5 often, but it occurs. These people, of course, are
6 trying to make a brief for their own products.
7 Naturally. That is what they are paid for, but as I
8 mentioned, I think that usually they are fairly well
9 informed about it, and if they are not they have usually
10 told me.

11 The odd man is purely and simply a salesman
12 and doesn't know too much about it, but I wouldn't
13 hesitate to say in my own experience this has been the
14 exception, not the rule.

15 MR. PRICE: They are well qualified?

16 DR. BRIEN: Physically, yes. In this day
17 and age, I am sure they have a hard time getting along
18 if they weren't.

19 The other point that has been brought out,
20 Mr. White raised it, was relative to cost. Now, I
21 always ask them if they don't tell me, and when I
22 teach young men who are to become doctors -- I might
23 say that I don't go into great detail about cost, but
24 I do point out in a more than a general way where they
25 lie, and a sensible usage of medicine should take
26 place, bearing in mind this factor.

27 The detail men have various information when
28 they come to see you, including sometimes the manufactured
29 substance. They have varying forms of literature,
30



1 the most useful of which, and this is the place where I
2 think that a great deal of the advertising matter that
3 is sent in the mails is filed, in a large basket, but
4 one thing that a good many doctors do is file a little
5 card that most pharmaceutical houses include with
6 perhaps papers relevant to the product, or with brochures
7 relevant to it, because it will go in a small filing
8 box. A good many doctors do hang onto that. I know.
9 I have inquired over the last few years relative to
10 this.

11 It is a very good source of explanation.
12 That card usually doesn't have any indication of what
13 the cost of medication will be. Now, unless the man
14 inquires or he has people trained to tell him about it,
15 he won't get it, especially if that is just left for
16 him.

17 MR. BRYDEN: Would it be true to say that a
18 good many of the detail men may know more about matters
19 of pharmacy than the average physician they visit?

20 DR. BRIEN: That statement I would have to
21 modify a little bit, and I would modify it in this way,
22 that with respect to a particular drug, any number of
23 drugs, particularly new ones, a detail man might have
24 considerably more knowledge about it, at least he would
25 have been told about it or read more than doctors have
26 about it, yes, that is perfectly true. He would have
27 nothing like the knowledge of the background and the
28 use of medication that most doctors would have, but he
29 might well know more about a certain number of new things,
30

1 yes. That is his business.

2 MR. BRYDEN: Since he is an interested
3 party, I am just wondering if that might put the doctor
4 at something like a disadvantage in trying to assess
5 the story he is giving because after all, he is
6 basically an interested party trying to sell a product.

7 DR. BRIEN: Yes, and they vary greatly with
8 the people who dispense this information, but it is
9 very interesting, Mr. Bryden, to watch this over a
10 period of time. I have done it in my present posi-
11 tion since the end of the war, and to see how people
12 in that particular branch of the provision of drugs
13 change. Some of them do not change, and there are
14 others who come and go as I mentioned before.

15 A good many of them are very solid citizens
16 and they are not working on price or on the money alone.

17 MR. SUTTON: Approximately how many companies
18 in Ontario would use such representatives?

19 DR. BRIEN: I am afraid I cannot answer that,
20 Mr. Sutton, but I think, Mr. Chairman, Mr. Menzies, who
21 has been the past president of the Pharmaceutical
22 Manufacturers Association over here might be able to
23 tell you accurately. I don't know.

24 THE CHAIRMAN: Thank you, Dr. Brien. Are
25 there any other questions?

26 MR. PRICE: What knowledge would these
27 detail men have of their competitors' products? It seems
28 to me it is rather important that they compare them.

29 DR. BRIEN: Were you ever in a hotel when
30



1 there was a pharmacy convention? I was in one, in
2 fact I spoke to the ORPA last week. They have a pretty
3 fair idea, in many instances, and furthermore, at times
4 some of them have -- they don't have the temerity
5 to run each other down. I don't think that I have had
6 that happen, and I think I would be very inclined to
7 usher the young man out because he would likely be a
8 young man. They occasionally refer to the differences
9 in prices of similar products that they make, but I
10 think the answer is they probably know as much about
11 what their competitors are doing as various automobile
12 companies do. I think they would be pretty similar.
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1 THE CHAIRMAN: It is a competitive world,
2 doctor.

3 DR. BRIEN: It is.

4 THE CHAIRMAN: Thank you for your assistance.
5 It may very well be that we will be calling on you at
6 a later date.

7 DR. BRIEN: I will be delighted to come.

8 THE CHAIRMAN: We will have a five minute
9 recess.

10
11 --- A short recess

12
13 --- Following the recess

14 THE CHAIRMAN: The next brief is that from
15 the Ontario Hospital Services Commission. I will ask
16 Dr. Ian Urquhart to come forward.

17 DR. URQUHART: Mr. Chairman and gentlemen,
18 I have submitted my brief to most of the members of the
19 Select Committee, and I shall read it to you.

20 It is my privilege to present to you today
21 something in the nature of a summary of the organization
22 and function of the Ontario Hospital Services Commission.
23 It is my purpose also to indicate its policy in relation
24 to the subject under study by this Select Committee.

25 You will recall that the whole question of
26 hospital insurance was studied thoroughly by the
27 Government and the Health Committee of the Ontario
28 Legislature in 1956. As a result of this study, the
29 Ontario Hospital Services Commission was constituted,
30 a corporation without share capital by The Hospital



1 Services Commission Act, 1956, and was continued
2 under the 1957 Act and its subsequent amendments. It
3 was to be an independent corporation similar in nature
4 to the Workmen's Compensation Board and the Hydro
5 Electric Power Commission. It was to be composed of not
6 fewer than three and not more than seven members.

7 The main functions of the Commission were

- 8 (a) to develop a balanced and integrated system
9 of hospitals and related health facilities
10 throughout the province. This involves the
11 approval of the establishment of new and
12 additional hospital facilities and the
13 administration of the hospital construction
14 grant system; and
15 (b) to administer a system of hospital insurance
16 including diagnostic services and, if it is
17 felt desirable, out-patient services and home
18 care services. This involves the determination
19 of the amounts to be paid to hospitals for
20 approved services performed for insured
21 persons under any such system.

22 The first Commissioners were appointed by
23 Order-in-Council dated August 1, 1956 (effective June 30,
24 1956) and to them was given the not inconsiderable task
25 of planning the development of policies and procedures,
26 so that the plan could come into operation on 1 January
27 1959.

28 During this period the original Commissioners,
29 Mr. Swanson, Monsignor Fullerton and Dr. Neilson,
30



1
2 worked assiduously with their associates to develop
3 practices and procedures which would stand up under the
4 stress of the operation of a plan which could involve
5 the well-being of virtually every citizen of the province.
6 Consultations were held with knowledgeable people in the
7 hospital, medical, insurance and related fields and
8 liaison committees were formed with such organizations
9 as the Ontario Hospital Association, the Ontario Medical
10 Association, etc. The services of well-known firms
11 of management and economic consultants were employed in
12 order that the conclusions reached by our own people in
13 regard to costs etc. could be checked.

14 It thus became possible in the fall of 1957
15 to release to the public the list of benefits and the
16 costs of the plan. It should be noted that at that
17 time the premium rates were struck to hold for a period
18 of two years. We have been gratified to find that by
19 and large our calculations have been proven to be
20 reasonably correct.

21 During this period also, it became necessary
22 for the Commission to think through to a conclusion its
23 proper relation to the hospitals of the province. The
24 Commission is concerned with the administration of a
25 huge insurance program involving some 5.5 million of
26 the people of the province. This involves not only the
27 collection of premiums but also the payment of money to
28 hospitals for services rendered to insured persons who
29 became hospitalized by reason of medical necessity. The
30 plan is, however, much more than an insurance program,



1 because it is so constructed as to involve the
2 Commission in such matters as adequacy of facilities,
3 quality of care and effective utilization of resources.
4 These many responsibilities made it imperative that the
5 role of the Commission be clearly defined in these areas
6 well before the plan actually came into effect.

7
8 The first principle to be elaborated had to
9 do with the autonomy of the hospital. For the most
10 part, hospitals had been independent organizations
11 within a community, governed by a voluntary Board of
12 Trustees and operated by suitably trained lay and
13 professional staff. The activities of the hospital
14 were supported and enhanced by a number of local
15 voluntary groups, who gave freely of their time and of
16 their substance in their desire to be of help, not only
17 to the hospital but also to their less fortunate
18 neighbors who needed hospital care.

19 It seemed to us that it would be unwise to
20 disturb a situation in which there was so much to commend.
21 Accordingly, it was determined that in so far as was
22 possible the autonomy of the hospital would be maintained.
23 The right of the hospital to conduct its own affairs
24 would be respected. This has become a basic principle
25 in Ontario.

26 The second principle which seemed to us to be
27 equally fundamental had to do with the role of the
28 physician in the working out of the plan. You will be
29 aware that the benefits of the plan become available to
30 an insured person who is admitted to hospital as an in-



1 patient by reason of "medical necessity". It is
2 obvious that only a physician can determine "medical
3 necessity". Indeed, one could go further and point
4 out that it is the physician who admits a patient, orders
5 diagnostic services, prescribes medication and, in
6 due course, discharges the patient from hospital. No
7 lay person can interfere in these functions. To do so
8 would be to interfere in the right of the individual to
9 receive medical care from his physician. The
10 Commission took the view, therefore, that where
11 medical necessity was certified to by a physician it
12 could not do other than recognize the service, provided
13 it fell within the terms of reference of the Act and its
14 regulations.

15
16 It must be remembered that this same Act and
17 regulations place a responsibility upon the Commission to
18 see that payments to hospitals are for services properly
19 a charge against the Commission. This could present
20 something of a problem since the term "medical necessity"
21 is not interpreted always in the same way by all physicians,
22 nor do any two patients with the same diagnosis
23 necessarily have the same degree of medical necessity.
24 Indeed, it would be surprising if such were the case.
25 I make this point solely to indicate that there is, and
26 must be, proper scrutiny of claims presented by a
27 hospital to the Commission for payment. The Commission
28 is receiving understanding, co-operation and help from
29 the profession so that such problems as exist in this
30 area gradually are being resolved.



1 One further basic principle, and one which
2 provides a very real link between the hospital and the
3 Commission, is the matter of budget review. The
4 hospital is expected to produce a realistic budget which
5 sets out clearly the anticipated operating expenses of
6 the hospital for the calendar year. This budget is
7 submitted to the Commission for review and approval.
8 Once approved on the basis of allowable costs, the
9 hospital is expected to live within its estimates. In
10 this way the senior partner, i.e. the Commission, is
11 kept informed of the projected expenditures of the
12 junior partners, i.e. the hospitals, and thus is able
13 to assess the rate of remuneration on the basis of
14 anticipated patient days. Quarterly reports and settle-
15 ments keep this information up-to-date. I may say that
16 every item of projected expenditure is related to past
17 experience, not only in a particular hospital but also
18 in hospitals of similar size in comparable communities.
19 A considerable accumulation of information of this kind
20 is now available.

21 I have devoted some time to the presentation of
22 these basic principles - namely, the Commission's
23 views as to the autonomy of the hospital, the place of
24 the physician in the working out of the plan, and the
25 budget review program, because they have a bearing on
26 the Commission's position in relation to the subject
27 under study by this Select Committee.

28 For example, I do not think that anyone can
29 debate the fact that the choice of medication must rest
30



1 with the physician. The Commission were so conscious
2 of this that at a very early date the profession were
3 asked to recommend an appropriate policy. As a result,
4 no restriction is placed upon the provision of recognized
5 drugs to the patient in hospital because of medical
6 necessity. The profession, in suggesting policy,
7 also requested that they have the opportunity to assess
8 the situation where the costs of this benefit appear to
9 be excessive or out of line with prevailing practice.
10 This was agreed to by the Commission, and you are aware,
11 no doubt, that pharmacy committees are active in a
12 great many of our hospitals.

13 It is the responsibility of the hospital to
14 provide the drugs requested or prescribed by the physician.
15 The pharmacist working with the pharmacy committee of the
16 hospital will order adequate amounts of the indicated
17 drugs from the supplier. Obviously, this is a local
18 operation under the sole jurisdiction of the hospital.
19 Any interference in this area by the Commission would
20 result in loss of autonomy of the hospital.

21 The total cost of drugs purchased by a public
22 general hospital in any one year is on record with the
23 Commission since it is a budget item. In the budget
24 review process this is related to the past experience
25 of the particular hospital and to the number of patient
26 days. It is to be noted that the total cost of drugs
27 purchased in 1958 in 153 public hospitals amounted to
28 \$6,892,375.56. In 1959 this had increased to
29 \$8,132,068.50, an increase of 18%. This increase must
30



1 be related to patients treated or better to days of stay
2 in order to understand its true significance. Patient
3 days of stay in 1959 were 6.7% greater than in 1958.
4 Thus, part of the 18% increase in the total cost of
5 drugs purchased in 1959, as compared with 1958, can be
6 attributed to the 6.7% increase in patient days for which
7 necessary drugs were provided. The balance of the
8 increase may mean that under the plan patients in
9 hospital now can receive necessary drugs without regard
10 to cost -- a factor which should represent better care
11 for the patient. Perhaps these figures will be more
12 meaningful if they are translated into cost per patient
13 day. The cost of drugs on the average in 1958 was
14 approximately 75 cents per patient day. In 1959 this
15 figure was 84 cents per patient day. It will be
16 interesting to see what the comparable figure will be for
17 1960.

18
19 In conclusion, I would repeat that in the
20 view of our Commission, the physician must have the
21 right to prescribe for the patient the medication which,
22 in his opinion, serves best to restore him to health.
23 The hospital must make these drugs available in the
24 hospital pharmacy. Responsibility in these areas must
25 remain at the local level. The Commission would not
26 wish it otherwise.

27 THE CHAIRMAN: Dr. Urquhart, would you
28 outline for the Committee some general information with
29 respect to the allowance of the daily rate for hospitals,
30 having in mind the amount allocated to drugs, the drug



1 allowance, and covering such matters as: Is the
2 Commission's allowance to the hospital actual, is it
3 adjusted to an actual figure each year, or is it an
4 arbitrary allowance and is it the same for each
5 hospital?

6 DR. URQUHART: I think perhaps I could go
7 back a little bit and say to you that when the plan was
8 first projected, and in the early years before the
9 plan came into being, a good deal of work was done
10 with the hospitals in order to get them onto a proper
11 budget system.

12 Some hospitals, of course, were on the
13 proper budget system, but there were some hospitals
14 who worked without true budgetary processess.
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1 DR. URQUHART: Early on that indoctrination
2 went on by means of institutions and so on so that
3 hospital administrators became familiar with the ways
4 in which hospital accounting should be done. Following
5 that, a trial budget was prepared in the year 1957
6 for 1958 and this gave us a lot of figures as to what
7 was happening in the hospital field throughout this
8 province. These figures were gone over, they were
9 compared with such information as was available and
10 is still available in the reports for previous years
11 and gave us something of a base line as to what hospital
12 costs actually were.

13 Then, in the fall of 1958, budgets were
14 submitted to the Commission from all the hospitals and
15 again these were gone over, were discussed with the
16 administrators of the various hospitals and on the
17 basis of this study, the total budget figure for a
18 hospital was arrived at. This budget figure then was
19 related to the anticipated number of hospital days.
20 In other words, the number of patients that were in the
21 hospital and for how long so that a per diem rate which
22 really is an interim method by which hospitals can be
23 paid was struck. This was the per diem rate and the
24 hospitals operated on this basis through 1959. Now,
25 through that period, of course, this was a trial period
26 in a sense, the hospitals had not had too much experience
27 with this sort of operation. I would say too, that
28 the Commission had not perhaps too much experience with
29 this kind of operation and therefore, there were a number
30



1 of budget adjustments; some things had been for-
2 gotten in some of the hospitals and some things came
3 up later on. These were adjusted. Similarly in
4 1959, budgets came in from the hospitals and on the
5 basis of the 1959 budgets, the 1960 costs and hospital
6 days and, there, per diem rates have been struck.
7 The budget consists of food costs, drug costs,
8 maintenance costs of all kinds. All my people who
9 are involved in this are hospital administrators, they
10 have been hospital administrators and they know a
11 good deal about the average amount that should be in
12 each hospital or in hospitals of various sizes; for
13 instance, teaching hospitals have a little different
14 situation to community hospitals and so on. I cannot
15 go any further than that because it is detail which
16 my staff attend to and, as Chairman, I do not get into
17 this to a very great extent. Does that answer your
18 question?

19 THE CHAIRMAN: Yes. Does it follow in
20 establishing and approving the budget of a hospital that
21 one hospital, say the Princess Margaret, may have a
22 higher daily drug allowance than another hospital?

23 DR. URQUHART: Yes, that could happen, because
24 of the drugs they are using and the things that they
25 are treating in that particular hospital. This
26 varies from hospital to hospital; drug expenditures,
27 expenditures on drugs vary from hospital to hospital
28 depending on the nature of their location, the kind
29 of work they are doing and so on.
30



1
2 THE CHAIRMAN: Without attempting to equate
3 any figures on a mathematical basis, from your
4 experience, is it possible a small hospital of 50 or
5 75 beds would have to pay more for its drugs of like
6 quality than a hospital of a larger size?

7 DR. URQUHART: I am sorry, I could not
8 answer that question. I can only deal with it on the
9 basis of the whole picture. We have that information
10 as to what the costs of drugs are in various hospitals,
11 but I have not that with me.

12 THE CHAIRMAN: At some later date, Dr.
13 Urquhart, I would think that information might be
14 of assistance to the Committee.

15 DR. URQUHART: We would be glad to give it
16 to you and actually this is the information which we
17 are preparing to provide to the Pharmacy Committee of
18 the Ontario Medical Association so they can look at it
19 to see what, in their opinion, is happening in some
20 of these areas.

21 THE CHAIRMAN: Is this the reference Dr.
22 Brien made?

23 DR. URQUHART: Yes, that is the reference
24 and I refer to that in my own brief.

25 THE CHAIRMAN: I suppose the fact is that
26 the figures available through the Commission's
27 operation are of such a recent nature that we are
28 just starting at the subject from the Commission's
29 point of view.

30 DR. URQUHART: You will note in regard to

1 drugs I stated it would be interesting to see what
 2 the figures would be for 1960 because we have to build
 3 by experience and one should not try to make conclusions
 4 from the results of one year's operation, which is all
 5 we have at the moment.
 6

7 THE CHAIRMAN: Could you tell the Committee
 8 what the percentage of population covered by the plan
 9 is?
 10

11 DR. URQUHART: Approximately 94 per cent
 12 of the population of this province are covered by the
 13 plan.
 14

15 THE CHAIRMAN: 94 per cent?

16 DR. URQUHART: Yes.

17 THE CHAIRMAN: And am I right then in
 18 saying that of all approved hospitals which is
 19 generally the membership of the Ontario Hospital
 20 Association in Ontario, then it would follow that we
 21 of the public are interested in 94 per cent of the
 22 drug bill.
 23

24 DR. URQUHART: I think we could be
 25 interested certainly in that.
 26

27 THE CHAIRMAN: Have you any knowledge of the
 28 basis of pricing of drugs to the patient?
 29

30 DR. URQUHART: No, I have no knowledge of
 that at all.

THE CHAIRMAN: Is there any principle which
 exists with respect to the mark-up of drugs in the
 hospital pharmacy without being charged into your plan?

DR. URQUHART: As far as I know, they are

1 put in at cost, it is a cost and all we can pay is
2 cost under our agreement with the Federal authority.

3 THE CHAIRMAN: So that by this legislation
4 or agreement, there is a limitation on the drug price
5 factor which gets in as a charge to the Commission.

6 DR. URQUHART: It must be cost.

7 MR. BRYDEN: How is cost termed? What is
8 termed "costing"?

9 DR. URQUHART: I suppose I should say that
10 I am a doctor and not an accountant.

11 MR. BRYDEN: Perhaps it is not a fair
12 question to ask you.

13 DR. URQUHART: The point I would make is
14 that the cost of operation of a hospital pharmacy would
15 involve the space, the actual cost of drugs as
16 purchased; that would be our cost, that would be the
17 portion that would be put in the budget.

18 MR. BRYDEN: It is the cost of dispensing?

19 DR. URQUHART: Yes -- staff of the hospital.

20 MR. SUTTON: You mentioned a figure in
21 1958 of 75 cents per patient day, does this indicate
22 a higher price for drugs or a larger quantity of drugs?

23 DR. URQUHART: That is a rather difficult
24 question to answer factually because one does not know
25 that, but one would suspect that what Dr. Brien said
26 is true, we are obviously having more patients in
27 hospital by 6.7 per cent, therefore, more people are
28 getting drugs.

29 MR. SUTTON: So that is taken care of by the
30

1 patient day?

2 DR. URQUHART: The number of patient days,
3 the number of patients in hospital, the total days
4 they are in hospital and divided into the cost of
5 drugs gives you a figure of so much.

6 MR. WREN: May I ask, Dr. Urquhart, has
7 the Commission formed any knowledge as to who con-
8 stitute the remaining 6 per cent of the population?

9 DR. URQUHART: We have some studies going on
10 on this and I think that it is the sort of thing that
11 one would find varies from time to time as various
12 studies are done. There are people, some of whom you
13 might know, who would never in this world think of
14 buying insurance; they are feckless people. Secondly,
15 there are people who are reasonably well-to-do and
16 do not believe in insurance, they do not bother buying
17 it. There are people who are roving from one province
18 to another and perhaps not here long enough to get
19 established. There are people who are moving from
20 single status into married status, who pay directly
21 into the groups and from groups they pay direct. There
22 is a certain loss in there. This is a figure based
23 on a calculation made by DBS.

24 MR. WREN: Have you any educated guess as
25 to who the major number would be of that 6 per cent?

26 DR. URQUHART: I think the feckless type
27 of people who are up in the northern woods and so on
28 and do not bother with this sort of thing. I am sure
29 you have run across them.
30



1 THE CHAIRMAN: Any further questions,
2 gentlemen?

3 Well, Dr. Urquhart, we certainly will be
4 calling on you and your organization for some assistance
5 in the future and possibly some of the studies which
6 are presently underway would be available to us.
7 Thank you for coming here.

8 DR. URQUHART: We will be very glad to be
9 of help, Mr. Chairman.

10 THE CHAIRMAN: That concludes the
11 hearing for today. Tomorrow morning we will start
12 at 10.30 and proceed with the brief from the Ontario
13 Hospital Association.

14 MR. BRYDEN: Ten o'clock or ten-thirty?

15 THE CHAIRMAN: I see Mr. Fleming in the
16 group. Mr. Fleming, have you any idea of the length
17 of your presentation?

18 MR. FLEMING: I am instructed that it will
19 take from three-quarters of an hour to one hour to
20 read the brief but what time will be spent on questions
21 I do not know.

22 THE CHAIRMAN: Perhaps we should say ten
23 o'clock. We will adjourn now until ten o'clock
24 tomorrow morning.

25 --Adjournment.
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Select Committee on Drugs

HEARINGS

HELD AT

PARLIAMENT BUILDINGS

TORONTO

ONTARIO

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SELECT COMMITTEE ON DRUGS

Proceedings of hearings
held at Parliament Buildings,
Toronto, Ontario, on Thursday,
the 16th day of June, 1960,
at 10.00 a.m.

COMMITTEE:

MR. H. L. ROWNTREE, Q.C., Chairman

MR. A. WREN

MR. J. A. FULLERTON

MR. J. TROTTER

MR. R. E. SUTTON

MR. R. J. BOYER

MR. N. WHITNEY

MR. H. J. PRICE

MR. K. BRYDEN

MR. J. WHITE

MR. G. F. LAVERGNE

MR. S. J. GADSBY, F.C.I.S., Secretary



Thursday,
June 16, 1960.

1 --- On Resuming at 10.00 a.m.

2
3 THE CHAIRMAN: This morning we were to
4 proceed with hearing a statement from the Ontario
5 Hospital Association. Mr. Fleming

6 MR. A. L. FLEMING: Mr. Chairman, the
7 brief of the Ontario Hospital Association has been
8 prepared by the Executive Director with the assistance
9 of his staff and he will read the brief, if you please.

10 MR. S. W. MARTIN: Mr. Chairman, and
11 members of the Committee, the brief that has been
12 prepared by the Association, I think, is before you
13 and the first page is merely a letter of transmittal
14 in which we express our appreciation for the opportunity
15 to be heard.

16 The second paragraph, I think I will read:
17 " Our presentation deals primarily with those
18 portions of the resolution which appear to us to
19 be within our province and concerning which we
20 feel it may have particular application to the
21 work of this committee."

22 Before continuing, Mr. Chairman, I may just
23 be permitted a short word of personal observation in
24 that in the approach, I think, that what we have done
25 is to take advantage of the charge which you gave to
26 those present on the first day, that the Committee
27 might be interested or could be interested in some of
28 the general background that would be associated with
29 the question of hospitals and then, in relation to
30 their situation and concerning the drugs which may be



1 the prime concern of this Committee.

2 I am reminded at this time of the situation
3 about two years ago, when I had the pleasure, perhaps,
4 of working with the Select Committee on Health of the
5 Legislature and, at that time, my good friend, Mr.
6 Ogilvie made a definition of an expert as being, breaking
7 it down into "x" being the unknown quantity and "spert"
8 being a drip under pressure. I hardly want to be
9 classified in that sense this morning, Mr. Chairman,
10 but rather, perhaps an optional definition which would
11 suggest, sir, that an expert might be a person who
12 has all the answers but does not quite understand the
13 questions.

14 The Ontario Hospital Association was formed
15 officially and constituted in 1924. The primary reason
16 for its inauguration was to assist in bringing about
17 a standardization of hospitals and to assist in formula-
18 ting educational programmes with the aim of assisting
19 hospitals to attain a higher standard of patient care.
20 The subsequent history of the Ontario Hospital Association
21 is a story of continuous service to the hospitals of
22 Ontario. In early 1941, formal Letters Patent as a
23 "corporation without share capital" were granted and
24 these included provision for the launching of the
25 Association's Blue Cross Plan for Hospital Care.

26 Association policy is determined by a Board
27 of Directors who are broadly representative of hospital
28 communities, both at the trustee and administrative
29 level. Institutional memberships number over 200
30



1 hospitals, reflecting the great majority of public
2 general and special institutions, including sanatoria,
3 in the province. Membership is voluntary and the
4 fostering and maintenance of self-autonomy of member
5 hospitals is a basic premise upon which Association-
6 hospital relationships function. Tangible expression
7 of this concept is seen in the organizational structure
8 of the Association wherein a number of standing and
9 special committees, comprising in the main practising
10 hospital people, help form the various aspects of
11 Association programming. The permanent secretariat of
12 the Association has its headquarters in Toronto.

13
14 In addition to the membership and committee
15 structure as outlined, provision is made in the
16 constitution for sections or "special branches of
17 hospital service". These comprise the following groups:
18 trustees, women's hospital auxiliaries, accountants,
19 nursing administration, medical record librarians,
20 dietitians, pharmacists, laboratory technologists,
21 engineers, housekeepers, purchasing agents, and
22 laundry managers. The sections, whose members, in
23 some instances, also have their own provincial
24 professional society or association, constitute an
25 advisory group in their particular specialties in
26 matters concerning hospitals. For its part, the
27 Association offers its planning and organizational
28 resources for meetings and educational programmes which
29 the sections may wish to have conducted. Again, the
30 Association-section relationship is a flexible one,



1 providing opportunity for co-operative development as
2 well as individual initiative.

3 The Ontario Hospital Association offers many
4 educational and advisory services to its members at
5 large. An annual convention, institutes and workshops
6 for hospital personnel, accounting and public relations
7 programmes, special studies on topical problems, and
8 publications of various kinds, are a cross-section of
9 the functions in which we are engaged. Close and
10 continuous liaison with our national organization, the
11 Canadian Hospital Association, agencies of the Provincial
12 Government and various provincial, professional organ-
13 izations such as the Ontario Medical Association, the
14 Registered Nurses' Association of Ontario, as well as
15 such international organizations as the American Hospital
16 Association, comprise a further facet of its activity.
17 It is in keeping with this latter concept, viz.
18 representation, that this presentation is being made on
19 behalf of our member hospitals.

20 As a preliminary to our consideration of the
21 subject of the resolution with which this Select
22 Committee is dealing, it was felt a brier description
23 of the development of our present hospital system would
24 be in order. As well, a concise review of the public
25 hospital structure and some of its basic components is
26 included in the hope it may provide useful background
27 information, not only for this presentation, but for
28 the continuing deliberations of this Select Committee.
29 A sketch outline of an abbreviated organization chart of
30



1 a medium-sized general hospital is also attached, as
2 Appendix I, for reference.

3 I might say, this is in the back of the
4 book and it is to this that I may make some reference
5 as I go along, with your permission, Mr. Chairman.
6

7 THE HOSPITAL STORY

8 The original concept of hospital service was
9 an obligation assumed by the church to care for the
10 sick and suffering, with the result that hospitals were
11 more ecclesiastical in nature than medical. Faith and
12 love were predominant while necessary care and treatment,
13 as we know it today, were almost non-existent.
14 People admitted were received chiefly for isolation and
15 their chances of leaving the institution alive were
16 extremely poor. This fostered the old and I might
17 say outdated concept that hospitals were places where
18 one went to die.

19 Gradually a change in sponsorship of hospitals
20 began to occur. Various groups, including commoners
21 and noblemen, motivated by a desire to do something for
22 the needy, either converted parts of their homes to such
23 purposes or established asylums where the unfortunate
24 could be admitted. Here, too, medical care was
25 limited, but this changing pattern of sponsorship re-
26 sulted in what might well be termed the prototype of
27 the community hospital as we know it today.

28 As the need for hospital services became more
29 evident, skilled fraternal organizations and municipalities
30 began to provide facilities for caring for the sick.



1 In addition, certain doctors who were without hospital
2 affiliation, or who were identified with government
3 hospitals, proceeded to organize their own sanatoria to
4 provide for paying patients. However, in spite of
5 the increase in the number of these institutions, the
6 quality of patient care remained low. In some instances,
7 conditions under which this care was provided were so
8 filthy, unventilated and contaminated that they actually
9 helped in the spread of disease instead of stopping it.

10 The development of ether as an anaesthetic in
11 the 1840's was to have a profound effect upon hospitals
12 as it opened the doors to real progress in surgery.
13 But anaesthetics, without cleanliness, were not enough
14 to assure safe surgery and the mortality rate remained
15 high until the second half of the 19th century when
16 antiseptics began to be accepted and later, asepsis --
17 freedom from bacteria.

18 Another complicating factor in the provision
19 of good care was the state of nursing which had been
20 deplorable up to the mid-19th century. It was Florence
21 Nightingale, the founder of modern nursing, who was
22 to make the change that established a new trend in
23 hospital techniques. Miss Nightingale's bedside nursing
24 developments, particularly in relation to principles
25 of sanitation and hygiene, lowered the death rate
26 dramatically and were eventually to save many lives as
27 their application became more widespread.

28 It was about this time that hospitals began to
29 increase their aims and objectives to embody a fourfold
30



1 function -- patient care, research, education and
2 preventive medicine. The provision of food and shelter
3 for the insane and diseased, which had been the
4 hospital function up to this time, became a secondary
5 feature as the development of new ideas in medicine and
6 surgery were incorporated into the care provided.
7 Thus, from their humble beginning and because of the
8 intense co-operation between hospital people and members
9 of the medical profession, hospitals have become centres
10 of healing, vital to the welfare and progress of our
11 communities.

12 We have here a list of hospital categories.

13 Today's hospitals fall into three major
14 categories insofar as ownership is concerned: voluntary
15 non-profit, governmental, and private.

16 Voluntary Non-profit - by far the greatest number
17 of hospitals in Ontario are the voluntary non-
18 profit hospitals and as of December 31, 1958 --.
19 We may have used some more up-to-date figures.
20 We used those because they are published. They
21 include 162 public general hospitals, 18 Red Cross
22 Outpost hospitals, 12 convalescent hospitals, 14
23 hospitals for the chronically ill, plus a number
24 of sanatoria for tuberculosis.

25 Governmental Hospitals - the second major owner-
26 ship category are the governmental hospitals.

27 These include, federally - those of the Armed
28 Services, the Department of Veterans Affairs, the
29 Department of National Health & Welfare, and
30



1 provincially - the Ontario Hospitals for the
2 mentally ill. The Canadian Hospital Directory,
3 1960, lists some 34 institutions in this category
4 of which 5 are federal nursing stations.

5
6 Private Hospitals - the third major classification
7 are the private hospitals operated for profit.
8 Such hospitals are nearly all small institutions
9 and, as of December, 1958, there were licensed
10 some 53 such hospitals operating within Ontario.

11 Just for a moment, I would like to speak
12 about the Community Hospital here, and the hospital's
13 role.

14 The role of the community hospital today
15 embodies a fourfold function:

16 (a) Patient Care - the continual development of
17 a high standard of patient care leading to better
18 health and longer life for the citizens of the
19 community it serves.

20 (b) Education - providing, in varying degrees
21 and depending on its size, a means for the
22 education of doctors, nurses, and skilled
23 professionals whose specialized knowledge is essential
24 to the practice of modern medicine.

25 (c) Research - again, in varying degrees and
26 depending on size, participating in programmes of
27 research for new and improved techniques and
28 treatments.

29 (d) Preventive Medicine - providing encouragement
30 and support to the medical profession in developing

programmes designed to keep people well.

THE HOSPITAL TRUSTEE

A most important contributing factor to the advancement of hospital work has been the devoted interest and unselfish support of certain individuals who, either singly or in conjunction with church groups or fraternal organizations, have established the voluntary pattern which characterized our public hospital system. These community leaders constitute what we know today as hospital trustees or, in the case of Sister hospitals, members of their advisory boards.

I might just interject here, sir, that hospitals in Ontario of the public variety are usually incorporated. They can be incorporated either in a private bill or under the special provisions of the Companies Act; so that in this sense "trustee" would be synonymous with "directors or a board of directors".

It is the hospital trustee who has been responsible, to a large extent, for fostering and preserving the principle of local hospital autonomy.

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1
2
3 The hospital, if it is to serve its community efficiently,
4 must have its roots deep in that community with its
5 control vested in citizens who are truly representative
6 of the area. It is therefore the results of the tire-
7 less efforts of the over 3,000 trustees and advisory
8 board members of Ontario's public general hospitals,
9 this does include the sanatoria because they operate
10 in much the same fashion, that have been responsible
11 for raising the standard of hospital care in Ontario
12 to the point where it is the equal of any on this
13 continent.

14 The role of the trustee is essentially that
15 of forming hospital policy. Collectively, they can
16 thus be referred to as the hospital's governing board.
17 They assume complete authority over and the responsibility
18 for the conduct of the hospital, and serve as a liaison
19 between this important public utility and its voluntary
20 supporters. It is the governing board who are res-
21 ponsible first of all for establishing the facilities
22 required in terms of their assessment of community
23 needs and, secondly, for the appointment of a medical
24 staff, which constitute those members of the medical
25 profession who will be furnishing medical and surgical
26 care with the aid of those hospital's facilities, and,
27 the appointment of a nursing staff and other staff.

28 It is the governing board's obligation, too,
29 to enforce all regulations requisite to good patient
30 care, to see that the proper clinical records are



1 maintained, and to satisfy themselves that there are no
2 divergencies from approved hospital routine. They
3 must see that the medical staff is provided with
4 adequate facilities and, most importantly, it is the
5 governing board's responsibility to assume steward-
6 ship of all funds entrusted to its care. In summation,
7 it can be said that it is the hospital's board of
8 trustees who, at all times and under all conditions,
9 are primarily responsible for the total operation of
10 the hospital. It may be of interest that regulation 2
11 (1) under The Public Hospitals Act reads, in part, as
12 follows:"a hospital shall be governed and managed
13 by a board elected or appointed in accordance with
14 the provisions of the authority whereby the hospital
15 is created, established or incorporated."
16 Regulation 3 states: "The board shall be responsible
17 for the enforcement of the Act, these regulations and
18 the by-laws of the hospital."

19 The next section, Mr. Chairman, deals with
20 a very important voluntary aspect of hospital care,
21 the Women's Hospital Auxiliary.

22 Important to the over-all operation, and,
23 as further evidence of the community-based characteris-
24 tics of our public general hospitals, is the substan-
25 tial contribution made by members of another dedicated
26 volunteer group -- the women's hospital auxiliaries.
27 The origin of the hospital auxiliary may be traced
28 to the desire of certain well-disposed individuals
29 to render personal acts of service. The function of
30



1 the hospital auxiliary is to render service in any
2 manner that the Board of Trustees, as policy makers,
3 and the administrator as chief executive officer, may
4 recommend. Such service includes interpretation--
5 telling the hospital story -- financial support and
6 personal aid. Of the three, financial support was for
7 many years the major activity of auxiliary groups,
8 ranging all the way from substantial contributions to
9 new building programmes to donations for Christmas
10 greens. The trend today is to accelerate public
11 relations and in-service volunteer programmes without
12 reducing the financial support.

13 Many of the hospitals' coffee and gift shops,
14 designed primarily to serve patients, their visitors and
15 personnel, are operated by women's hospital auxiliaries
16 and provide them with substantial sources of year-
17 round revenue which is in turn used for the benefit
18 of the hospital. Auxiliary-sponsored fashion shows,
19 card parties, garden tours, concerts, bake sales, etc.,
20 are some of the methods used by auxiliaries to raise
21 funds, and the funds accruing from these enterprises
22 are allocated usually to specific projects agreed upon
23 by the group on the recommendation of the hospital
24 administrator.

25 In Ontario, there are 60,707 women's
26 hospital auxiliary members, and in 1959, through their
27 combined efforts, a total of \$754,349.55 was raised and
28 turned over either in cash or through gifts to Ontario's
29 public general hospitals.
30

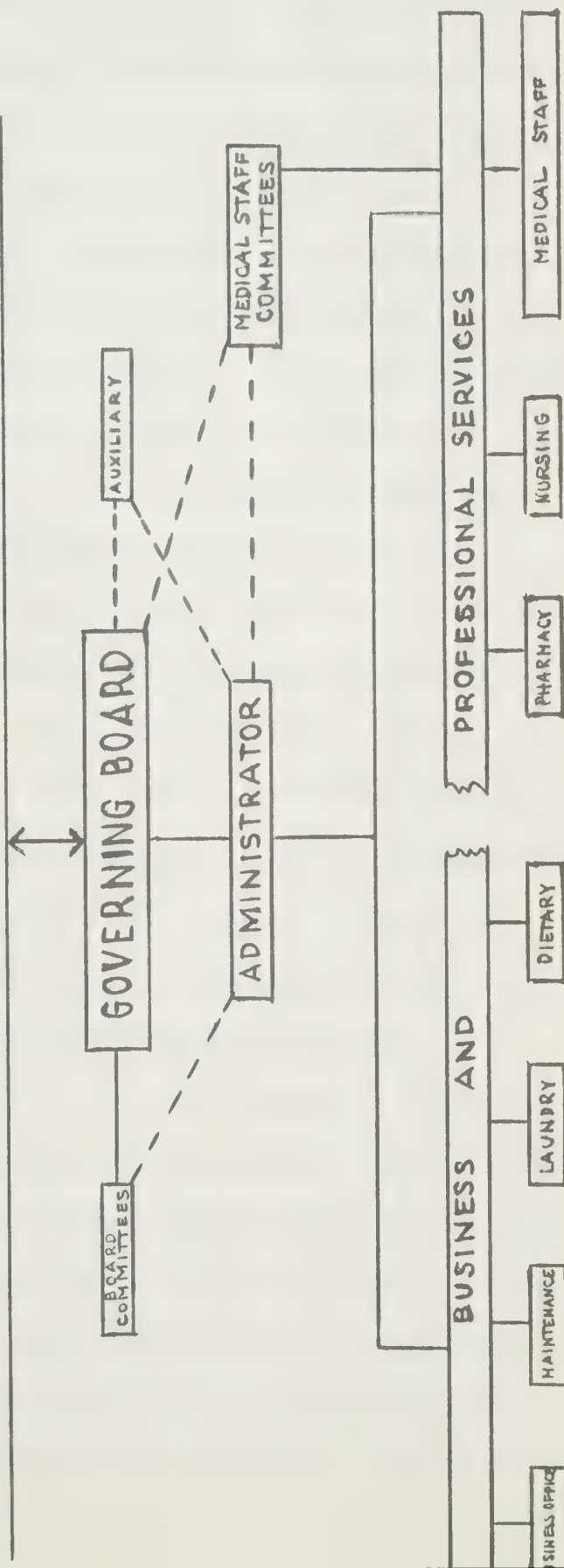


I think at this point, Mr. Chairman, I might refer you to the organizational chart at the back of your brief, just to perhaps get some of these groups into relationship as they might be.

APPENDIX I

SKETCH-OUTLINE
HOSPITAL ORGANIZATION CHART

COMMUNITY





1 You will notice at the top we have put the
2 Community, and the number of ways that they can
3 generate from there, and the next important item, of
4 course, is the Governing Board. Below that in direct
5 line is Administrator, and off to the left we have
6 included to some degree Boards that are usually broken
7 up into a number of Committees for efficient functioning
8 and to the left we have Auxiliary because it is an
9 exact line function of the hospital to a supportive
10 group, as I have outlined to you, and further to the
11 right you will notice the Medical Staff Committees which
12 come up from the medical staff of the hospital.

13 Now, there is a relationship between the
14 medical staff, Medical Staff Committees and the
15 Administrator for administrative purposes, but as you
16 know under the Hospitals Act, the medical staff also
17 has direct representation on the Governing Board of the
18 hospital under the regulations of the Public Hospitals
19 Act. I wanted to point this out visually because I am
20 going to comment on the rather unique position that the
21 medical staff and the organization medical staff does
22 occupy as far as the hospitals are concerned.

23 The rest of it is, you can see -- this is
24 not attempted to be drawn in exactly but only to give you
25 a brief idea; what appears on the sketch is not nearly
26 all of the hospital services which are covered in that
27 bottom part. It is mostly this top part to show the
28 line relationship of these various people to the Board
29 of Governors. Now, we come to the Medical Staff, Mr.



1 Chairman.

2
3 Regulation 6 (1) (a) (iii) under the Public
4 Hospitals Act states, in part, that the board shall
5 provide for the appointment and functioning of a
6 medical staff. To this end, a procedure for such
7 appointments, together with details of a medical staff
8 organization, including officers, committees, and
9 privileges are incorporated in the by-laws of the
10 individual hospital. When such by-laws have received the
11 required approval of the Lieutenant-Governor-in-Council,
12 they become the law affecting that particular hospital
13 along with The Public Hospitals Act itself and the
14 Regulations under it, and we should have added in
15 there, Mr. Chairman, the Hospital Services Commission
16 Act which now has a bearing also on some parts of this.

17 The fact that a hospital board has this
18 legal obligation and right to appoint the individual
19 members of its medical staff is important in under-
20 standing the public hospital -- physician relationship.
21 While it is recognized that a licence to practise
22 medicine, issued by the Ontario College of Physicians
23 and Surgeons, entitles a doctor to practise his pro-
24 fession anywhere within the province, it does not grant
25 him the privilege of using the facilities and equipment
26 of a hospital without first having satisfied the require-
27 ments of obtaining medical staff membership. It should
28 be noted, however, that in fulfilling its responsibility
29 in this respect, a board will ordinarily have the
30 advice and recommendation of the existing medical staff.

1 On the other hand, by inference, the board
2 has the right not to accept medical practitioners on
3 the hospital staff and this does not necessarily
4 connote that such doctors are incompetent or otherwise
5 undesirable. It may mean that the hospital facilities
6 are not adequate for a medical staff beyond a certain
7 size. In so far as teaching hospitals are concerned,
8 the medical staff, or at least what is known as the
9 active or attending staff portion of it, tends to
10 comprise individuals with specialist qualifications
11 because of the university affiliation and the teaching
12 programmes, and this inevitably means that some prac-
13 titioners do not so qualify.

14 Another important aspect of the individual
15 hospital -- physician relationship is that with very
16 few exceptions, the physician on staff receives no
17 remuneration from the hospital. Two of the notable
18 exceptions are in relation to radiology and pathology
19 which have long been considered traditional and
20 essential hospital services. In fact, radiological and
21 pathological services are among the benefits approved
22 for in-patients under the Hospital Insurance Plan of
23 this province. With such reservations, the point
24 can then be made that doctors on the medical staff of
25 a hospital have the use of facilities of the hospital,
26 but payment for personal medical services rendered
27 therein is strictly a matter between the doctor and
28 his patient. In addition to the question of
29 radiology and pathology, of course, the radiologist
30



1 and pathologist are treated equally as members of the
2 medical staff and become members of the Medical
3 Advisory Committee and thus have a slightly additional
4 responsibility in the hospital picture both in a
5 straight line function as well as in other responsi-
6 bilities in Medical Staff Commission. Primarily, they
7 are medical practitioners.

8 A final but very significant point, too,
9 which may be considered a guiding principle in the
10 medical staff organization of a hospital, is that the
11 medical staff be essentially self-governing in pro-
12 fessional matters. That is to say, while they are
13 responsible in the final analysis to the hospital
14 board, they alone have the clinical knowledge to
15 assess medical needs and prescribe treatment. In this
16 respect, therefore, they enjoy a reasonable degree
17 of autonomy, but as stated, always subject to The
18 Public Hospitals Act, the Regulations thereunder, and
19 by-laws within which their medical staff category
20 functions. This self-governing principle also applies
21 to control within their own ranks and frequently hos-
22 pital by-laws provide for definite committee procedure
23 to deal with what may be infractions of regulations or
24 accepted medical practice. Recommendations arising
25 out of such an assessment may require Board action.

26 HOSPITAL FINANCING

27 OPERATING COSTS

28 As of January 1, 1959, and in conjunction
29 with the launching of the new Hospital Insurance Plan
30



1 for the Province of Ontario, hospitals for the first
2 time went on what could be termed an inclusive rate
3 structure through which operating costs were included
4 in a basic daily rate. This rate includes the cost
5 of providing the patient with such services as
6 accommodation and meals, nursing, laboratory, radio-
7 logical and other diagnostic procedures with necessary
8 interpretations for the purposes of maintaining
9 health, drugs, biologicals and related preparations,
10 the use of operating room, case room anaesthetic
11 facilities, and, routine surgical supplies. This
12 inclusive charge per day is reimbursed to hospitals by
13 the Ontario Hospital Services Commission for all insured
14 patients and has virtually eliminated the large hos-
15 pital deficits which were fairly common prior to the
16 introduction of the new Plan. In short, it is the
17 per diem rate which covers the hospital's total
18 operating costs. We had some discussion on this with
19 Dr. Brien yesterday, this rate is also charged both
20 to the Commission and to those people who may not
21 have insurance but may be in as patients paying their
22 own way, so there is no difference in the rate that
23 you pay at the hospital be you insured or be you not
24 insured at the present time. That is the basic rate.

25 In 1958, the latest figures officially
26 available, the total operating costs of our public
27 general hospitals were in excess of \$151,071,000.
28 The breakdown of these costs by percentage would be
29 approximately: (Page 25, Annual Report on Public and
30



Private Hospitals in Ontario, 1958).

Salaries and Wages	67%
General Services, Maintenance, etc.	16%
Drugs, Medical-Surgical Supplies	9%
Dietary Services	8%

A figure I imagine you people are most concerned with is the 9%, and while we have not attempted to break this out, because I will come to that point in the hospital accounting later on, it does break out because the medical- surgical supplies include such things as dressings, all other types of instruments and things like that so that the 9% would break down further if you were to try and get at the drug cost, and as Dr. Urquhart indicated to you yesterday, this would break out roughly into about a 5 and 4 combination under that heading.

CAPITAL COSTS

The capital costs of a hospital include that amount of money necessary for new construction, to finance the extension of existing hospital facilities and to purchase new equipment. Interest on capital debt is also included in this category.

Funds for capital expenditures are largely found through philanthropy, local taxation and debentures, although combined grants from the Federal and Provincial governments cover approximately one third of the total cost of building additional facilities.

* * * * *

In proceeding to the broad terms of reference



1 contained in Motion No. 8, it was thought desirable to
2 relate our presentation as closely as possible to the
3 wording of that motion. Accordingly, we have attempted
4 to define our approach in terms of actual words used
5 therein.

6 The word "drug" is specifically defined in The
7 Pharmacy Act, 1953, as amended 1957, Section 1,
8 Clause (d) as follows. I believe Dean Hughes on
9 Tuesday indicated to you people that we had this.

- 10 "(i) any substance that is named in the latest
11 edition from time to time of the British
12 Pharmacopoeia, the British Pharmaceutical
13 Codex, the Pharmacopoeia of the United States
14 of America, the National Formulary, the New
15 and Nonofficial Remedies, the Canadian
16 Formulary, the Codex Francais or the Pharma-
17 copoea Internationalis, or
18 (ii) any preparation containing any substance men-
19 tioned in subclause i, or
20 (iii) any substance that is offered for sale or
21 sold for the prevention or treatment of any
22 ailment, disease or physical disorder,
23 but does not include any such substance or
24 preparation offered for sale or sold as, or as part
25 of, a food, drink or cosmetic or for any purpose
26 other than the prevention or treatment of any
27 ailment, disease or physical disorder."

28 The terminology, "pharmaceutical preparation", is not
29 similarly defined and it is being presumed that the
30



1 definition for "drug" can be considered all-embractive.

2
3 In interpreting the terminology, "present
4 methods and practices", we have adopted the period since
5 January 1, 1959, at which time the Ontario Hospital
6 Services Commission came into being under the Hospital
7 Services Commission Act. Although this does not infer
8 in any way that principles of operation of hospitals
9 have altered, certain requirements by virtue of the
10 Commission's responsibilities as the vehicle for the
11 provincial hospital insurance plan, as well as its
12 broad responsibilities regarding hospital services
13 generally, indicate the desirability of regarding
14 hospital operation, for purposes of this inquiry, in
15 terms of that time period.

16 In describing "methods and practices followed",
17 we have attempted to portray for the Committee what we
18 believe to be current practice, on the basis of pooled
19 knowledge of resource persons available to us in the
20 time at our disposal. It may be appreciated that it
21 would not be possible to delineate every variation which
22 may be in effect in the over 200 hospitals which exist
23 in this province, but with this reservation we feel we
24 are presenting the best factual information under the
25 circumstances.

26 The matter of "cost", per se, is dealt with
27 in several phases on a broad basis. We have not
28 attempted to provide a list of drugs used in hospitals
29 since the full scope of these is as broad as those
30 contained in the various publications mentioned in



1 Section 1 of The Pharmacy Act. I am sure that many of
2 you are familiar with this (indicating). This is
3 not an up-to-date copy, but this is the British
4 Pharmacopoeia. You can imagine just the extent of it
5 and the drugs that are involved in these documents.
6 It may be evident to the Committee that in the interests
7 of having a presentation ready for the early days of
8 this hearing we had to resolve a definite course of
9 action and the time factor precluded such specifics
10 as individual drug items. We would like to assure the
11 Committee, however, that the Ontario Hospital
12 Association desires to be as helpful as possible,
13 and to this end is prepared within the limits of its
14 resources to obtain such additional information as the
15 Committee in its discretion may feel it subsequently
16 requires.

17 THE HOSPITAL PHARMACY

18 The hospital pharmacy provides one of the
19 fundamental services involved in the care of the patient
20 and it is increasing in importance each day as medical
21 research continues to add new pharmaceutical products and
22 new techniques for the doctor's use. During the last
23 30 years new discoveries and advances in the method of
24 application of medication have included the development
25 of parenteral solutions, sulfonamides, antibiotics,
26 vitamins, and anaesthetics. With a greater number of
27 specific drugs and their more complicated treatment
28 regimes, it is more important than ever that certain
29 medications be immediately available and placed in
30



1 competent hands. Thus, the pharmacy is assuming a
2 greater part in patient care.

3 The primary functions of a hospital pharmacy
4 are to make drugs and pharmaceuticals readily accessible
5 for treatment purposes and keep them under careful
6 control; to provide up-to-date information in order
7 that the best choice of medicinal products may be made
8 by the physician; as well as to assist both physician
9 and nurse in the correct administration of the
10 product.
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1 Subsidiary or secondary functions may include:
2 purchasing of pharmacy products for the hospital manu-
3 facturing which may be merely dispensing and compounding
4 or may be a large scale operation; keeping and origina-
5 ting financial and other records; and participating
6 in the teaching of students, interns and residents,
7 and in medical staff education.

8 Most of our further comments on the hospital
9 pharmacy service will be in terms of the specific
10 terms of reference in the latter part of the resolution
11 itself, viz. purchase, distribution, analysis, storage,
12 inventory and accounting.

13 PURCHASE

14 For purposes of this presentation, we con-
15 sider this item to embrace policy as well as practice.
16 The majority of hospitals have what is usually known
17 as a Pharmacy and Therapeutics Committee composed of
18 members of the medical staff. This committee meets
19 to exchange professional views and in general to advise
20 the medical staff and the hospital administration on all
21 matters pertaining to the use of drugs in the hospital.
22 Where a pharmacist is on staff of the hospital, he or
23 she is usually secretary of such a committee. In the
24 absence or unavailability of a pharmacist, such as in
25 most of the smaller hospitals, the director of nurses
26 would normally act in such a capacity.

27 Basically, therefore, such a committee tends
28 to establish purchasing policy in so far as the needs of
29 the medical staff of that particular hospital is concerned.
30

1 Through experience, a list* -- and that is asterisked
2 and noted to refer to a foot-note which I will explain
3 later, Mr. Chairman -- of the main drugs required in
4 the hospital is eventually developed and this becomes
5 a framework or guide for continuing purchasing. The
6 quantities to be ordered will depend on many factors
7 and these will be referred to in subsequent sections
8 of the report.

9
10 While individual application of the foregoing
11 principles may vary to some extent, the essential point
12 we wish to make is, and this is, we feel, perhaps the
13 crux of the whole situation, and so is underlined.
14 It is the members of a medical staff who decide the kind
15 of drugs they wish the hospital to acquire for their use
16 in patient care. In the larger institutions, the
17 chief pharmacist is ordinarily responsible for ordering
18 the drugs required, utilizing his detailed knowledge
19 and experience as to quantities and sources of supply,
20 but in some instances, where there is a purchasing agent
21 on staff, the latter places the actual order upon the
22 specifications of the pharmacist. Again this is a
23 development based on specialization of function in the
24 more complex structure of the large hospital, and has
25 as its genesis the question of methods of improvement
26 and general specialization of administrative functions.

27 In the smaller hospitals, there likely will
28 be neither a pharmacist nor purchasing agent on staff.
29 The role of the latter is usually incorporated in the
30 duties of the administrator while the recommendations of

1 the medical staff as to pharmacy needs are carried out
2 by the director of nurses who may be the same person as
3 the administrator of the hospital. Since there is no
4 pharmacist on staff, it is customary for the pharmacy
5 service in the smaller institutions to be under the
6 supervision of a designated member of the medical staff.
7

8 It has not been possible for us to delineate
9 all variations in purchasing practice that may exist
10 among the many types and sizes of hospitals in the
11 province. In addition to factors already mentioned, the
12 location of the hospital and the ready accessibility of
13 the sources of supply may possibly have as much bearing
14 upon the quantities ordered as the availability, say,
15 of a volume discount. The nature and degree of storage
16 facilities for drugs have a definite bearing upon
17 purchasing policy in considering volume purchases and
18 the preservation of potency in certain items over a
19 period of time. The varying sizes of hospital and their
20 differing patient loads and categories of treatment will
21 obviously have a significant effect on the drug pur-
22 chasing policy and it is here that the decision of the
23 medical staff in the individual situation becomes of
24 paramount importance. The large teaching hospital, for
25 example, stocks many more items than others because of
26 the clinical research and teaching being done.

27 If any single aspect of purchasing policy
28 should be stressed, it is that quality of product must
29 continue to be the main criterion since the welfare of
30 patients is inseparably involved. Few, if any,



1 hospitals are known to have the staff and facilities
2 that would be required to do chemical analyses of every
3 item purchased, so that hospitals must depend on the
4 known reliability of the source of supply. This does
5 not infer there are not a considerable number of
6 reputable manufacturers and suppliers, but in the
7 final analysis, it is the individual hospital's own
8 experience, as reflected in the opinion of its doctors
9 and their clinical evaluation of drugs, that will
10 determine to a major extent where it places its orders.
11 We feel that our hospitals, regardless of size, are very
12 conscious of their responsibility in this matter and
13 continue to strive for the best possible operation
14 within their individual circumstances consistent with
15 the quality of product desired.

16
17 Reference has already been made to the
18 hospital insurance plan, and "in-patient services"
19 covered in the plan are listed in the regulations under
20 the Hospital Services Commission Act. Included in
21 these in-patient services are the following which are
22 of interest at this time. I am quoting from the
23 regulations of the Act.

24 "Regulation 1 (3) (b) (iv): drugs, biologicals
25 "and related preparations which are prescribed by
26 "an attending physician in accordance with accepted
27 "practice and sound teaching and administered in
28 "a hospital, but not including preparations sold
29 "under the Proprietary or Patent Medicine Act
30 "(Canada)."



1 Since the hospital must have its operating
2 costs covered by the Commission's per diem rate, such
3 a stipulation for drugs, while broad, also is restric-
4 tive and this will continue to have an obvious effect
5 on purchasing policy as well as aiding in the preserva-
6 tion of quality in the items obtained.

7 I would like to say a few words about a
8 formulary.

9 Formulary - As already indicated, the medical staff by
10 their treatment orders and prescriptions determine
11 what drugs are to be provided and it has been estab-
12 lished that eventually a pharmacy stock list is develo-
13 ped and is written down as an inventory. In a number
14 of instances an attempt has been made to stabilize this
15 list by securing some authority other than the indi-
16 vidual physician or pharmacist to determine what addi-
17 tions or deletions may be made. This then may be the
18 beginning of what is termed a formulary, and more
19 frequently hospital formulary. The Pharmacy and
20 Therapeutics Committee, already referred to, is the
21 group normally giving direction to such a project.
22 This is a Committee of the medical staff in which,
23 of course, a pharmacist would be active. In practice,
24 the committee studies and grades the effectiveness of
25 pharmaceuticals on the list using as a matter of
26 principle that what is most effective is likely to be
27 the cheapest in the treatment of the patient. The
28 committee then decides what items are to be included in
29 the formulary and to this end may set up certain rules
30



1 about the admission of new drugs. Frequent revision is
2 necessary and individual staff members may make rep-
3 resentation to the committee regarding the inclusion
4 of any item he may want to see in it.
5

6 Fully developed formularies usually contain
7 such items as a list of products by their official
8 name in English, together with a description of their
9 properties, chemical structure, dosage forms, and
10 stock sizes. Indexing is very important and products
11 may appear in alphabetical order within groupings
12 according to therapeutic use. In hospitals with ex-
13 tensive specialization among medical staff, such
14 groupings could be by medical departments for ease
15 of reference, that is as between medicine, surgery,
16 gynecology, obstetrics, etc. Cross-indexing to
17 terminology commonly used for certain products by the
18 medical staff contribute to the practicality of such a
19 formulary.

20 A consideration of a formulary and pur-
21 chasing generally, brings up the subject of buying
22 drugs by "generic" name. The term "generic" relates to
23 the scientific or pure chemical name given to a
24 particular product. Items may be so identified
25 or they may be produced under what is termed a
26 "brand name" and it is in this relationship that some
27 confusion appears to exist. Essentially, quality
28 considerations aside, the ordering of items by their
29 generic name tends to restrict the number of items
30 stocked and to make for a more concise inventory. The



1 term "generic" should in no way connote a cheaper
2 product in the sense of an inferior one and it is here
3 the matter of quality arises. A drug may be ordered
4 by its generic name from what is known as a generic
5 house, and, as in the case of all purchases, the hospital
6 must be in a position to feel it can rely upon the product
7 or supplier. In point of fact, a number of hospitals do
8 have stocks in varying proportions as to drugs purchased
9 under their generic name and under designated brand
10 names. This is, I think, similar to the experience
11 that was given to you by Dr. Brown as far as the
12 mental hospitals in the province were concerned.
13 The preference and wishes of the medical staff for
14 particular items are important factors in the
15 establishment of the stocks and to the extent that these
16 are professional people with specialized knowledge of
17 the effect of certain preparations in their treatment
18 regimes, must be accorded full weight in any purchasing
19 policy.
20

21 The matter of cost is naturally of considerable
22 importance to hospitals, and sound purchasing has as
23 much applicability to drugs as the many other
24 hospital commodities required. Reference has, and
25 will further be made, to the varying considerations
26 affecting the nature and amount of drug inventories,
27 but the point to be emphasized at this time is that the
28 costs of drugs which are incorporated in the per diem
29 rates are entered at net invoice price -- there is no
30 markup involved. Similarly, these drugs are Sales Tax

1 Exempt, under an arrangement with the Federal
2 Government, whereby public hospitals can purchase,
3 even if they are not for resale, they can be purchased
4 Sales Tax Exempt with a further consequent 9 to 10%
5 saving. I think we make that point, Mr. Chairman,
6 as a distinction from the drugs which might go out
7 through retail outlets which would not have that
8 privilege. A further point pertinent to consideration
9 of costs is that hospitals have received and continue
10 to receive substantial discounts on their drug
11 purchases. The larger hospitals have tended to
12 receive additional concessions by virtue of their
13 greater purchasing power and the possible advantage to
14 drug firms of having their products used in circumstances
15 where extensive clinical research and application is
16 taking place.

17 In considering drug costs and per diem rates,
18 we have been referring to insured, and also non-
19 insured, in-patients. There are 18 hospitals in this
20 province with what is termed an organized out-patient
21 department. Dr. Brien referred to the one at Victoria
22 Hospital in London yesterday briefly. These depart-
23 ments are designed to take care of the ambulatory
24 patient and those referred to specific clinics for
25 follow-up after a period of hospitalization. Tradi-
26 tionally, the great majority of patients accommodated
27 in this way have been of indigent or near indigent
28 status. Here we are using indigency in the term of
29 medical indigency, Mr. Chairman.
30



1 In short, little revenue is ever received
2 from any of them. While drugs are dispensed to out-
3 patients and at times, depending on ability to pay, a
4 token charge is made, the cost of operating an out-
5 patient department many times exceeds any off-
6 setting revenue. The situation has not changed with
7 the advent of the hospital insurance plan. Out-
8 patient services are not at present benefits under
9 the Hospital Services Commission Act. I say that
10 "in this sense", because there is some confusion in the
11 term "out-patients" in that under the Act, there are
12 certain provisions for emergency service following
13 accidents and so on, under the Hospital Insurance Act
14 which could be interpreted as walk-in walk-out services
15 without occupying a bed.

16 DISTRIBUTION

17 The distribution of drugs in a hospital varies
18 somewhat depending upon the size and nature of the
19 institution. In general it may be said that for the
20 larger hospitals, distribution is in three forms.
21 First, certain supplies are maintained on the wards
22 as routine stock. Secondly, individual prescriptions
23 are filled in the pharmacy according to doctors' orders
24 and are returned to the ward for a particular patient.
25 In this respect, a hospital pharmacy operates in very
26 similar fashion to the retail pharmacy in that these
27 numbered prescriptions are kept on file for re-orders
28 and/or reference. As may be appreciated, the volume
29 of prescriptions handled by a hospital pharmacy is
30 ordinarily much greater than in an individual retail



1 pharmacy. Thirdly, drugs are supplied, on doctors'
2 orders, to out-patients. In this latter connection,
3 it is generally the policy to provide just sufficient
4 of a drug supply to the out-patient as will suffice
5 until his next scheduled visit. In a number of
6 institutions, also, an emergency cupboard is main-
7 tained, often in the nursing office, or in large
8 hospitals on the floors themselves, to minimize having
9 to enter pharmacy stores during night hours.

10 In smaller hospitals much the same pattern
11 is observed save that no out-patient clinics are
12 involved. Too, in those institutions where no
13 pharmacist is on staff and certain prescriptions must
14 be obtained, arrangements are made with a local retail
15 druggist or druggists to provide the required items.
16 In some instances, arrangements have been made by
17 which a pharmacist from a local retail store actually
18 works part time in the hospital pharmacy, and this
19 provides, then, a day service for the hospital on a
20 part-time basis.

21 Narcotics are very carefully safeguarded
22 and controls must meet the requirements of federal
23 inspectors who make periodic visits to the
24 hospitals. In this sense, Mr. Chairman, we infer
25 that if you were to go into the hospital, you would find
26 that these are kept in locked places. They are kept
27 in locked cupboards and behind locked doors in the
28 distribution depots within the hospital. Other
29 controls used include departmental costing of issues to
30



1 floors for comparative purposes, therapeutic classi-
2 fications of use, and, periodic review of ward stocks.
3 The supply of drugs provided a ward for an individual
4 patient is generally restricted to three or four days with
5 any unused portion of the drug being returned to pharmacy
6 stock after inspection. Suitable arrangements are also
7 possible for the return of obsolete or expired drugs
8 to suppliers for credit.
9

10 Most hospitals, too, have adopted a policy of
11 an automatic stop order on certain drugs following a
12 specified period of time. For example, for such
13 items as narcotics a stop order might be effective
14 after 48 hours, whereas, antibiotics might run for
15 several days. In any event, unless the physician's
16 order should indicate the exact number of doses to be
17 administered or has specified the exact period of time
18 during which the medication is to be administered, or,
19 unless the physician has reordered a medication, all
20 drug orders for such items would be automatically
21 discontinued.
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ANALYSIS

There was some question in our minds as to the interpretation to be placed upon the term "analysis". Our conclusion, and the one on which our comments are based, was that it concerned the degree to which drugs were analyzed or tested upon receipt at the hospital or at least at some time following receipt. Again, analysis can mean a number of things, but we can say that in very few, if any, instances is there a chemical analysis done by pharmacists in hospitals insofar as the general drug supply is concerned.

Two main reasons may be cited for this: firstly, even where a pharmacist is on staff, our experience is that he is extremely busy doing his regular duties and there literally is no time to do this type of work. Also, the facilities required would be extensive and these ordinarily are not available in hospitals. I think we have had some demonstration of the extent of this from the report of the Attorney-General's Department on Tuesday. The pharmacist strives to purchase on the basis of known quality and relies to a major degree upon the reputation of the supplier and his own experience with that firm or firms. In short, since he has not the time nor facilities to do a chemical analysis, he tends to buy products which he has come to depend upon for maintenance of quality standards.

One might well ask, upon what does the pharmacist base his dependence upon these items? This

1 is a combination of several things. There is a physical
2 or sense analysis in that he is able to do a visual in-
3 spection, detecting variations in size, texture, etc.,
4 as well as detecting, in some instances, odours which
5 do not conform with what he has come to expect. In
6 short, this experienced person, as in other lines of
7 endeavour, develops certain rule-of-thumb criteria which
8 stand him in good stead. The opinions of the medical
9 staff as to patient reaction to drugs prescribed are,
10 of course, very important and these, too, provide
11 their measure of evaluation as to the effectiveness of
12 drugs and supplies.

13 THE CHAIRMAN: Mr. Martin, would this be a
14 convenient time for us to have a recess?

15 MR. MARTIN: I would welcome it, Mr.
16 Chairman, if you so wish.

17 THE CHAIRMAN: Yes. We will recess for
18 a few minutes.

19 --- Short recess.

20 THE CHAIRMAN: Gentlemen, if you are ready,
21 we will recommence. Are you ready to go on, Mr.
22 Martin?

23 MR. MARTIN: Yes, sir. I think, Mr.
24 Chairman, I left off at the top of page 14, under
25 the heading of "Storage", where I will pick it up.

26 The matter of storage could be considered
27 from several points of view, but in all cases there is
28 what might be termed a central stores or stockroom.
29
30



1 The size of the hospital will actually have a bearing
2 both on the amount and kind of storage space and
3 perhaps, as well, where it is located in the hospital.
4 Two of the major objectives should be uppermost in any
5 storage plan, viz., accessibility and control. The
6 many variations of physical layout and other hospital
7 needs make generalizations as to the former, that is
8 accessibility, rather meaningless for present purposes.
9 As for the latter, control, this is exercised in a
10 number of ways.

11 The storeroom is, of course, locked as is
12 the pharmacy proper when the staff are not present.
13 There is a definite policy regarding access to any of
14 the pharmacy supplies and only properly designated
15 persons are given this responsibility. Who is so
16 designated does vary with the size of hospital, but
17 there is normally no problem during the day when the
18 person in charge of the pharmacy service is present.
19 During the evening and night hours - and it is quite
20 apparent that our hospitals must go day and night,
21 365 days of the year - the night supervisor or person
22 of equivalent status has the responsibility of keeping
23 the key to the pharmacy and stores.

24 Entrance to the central stock is ordinarily
25 kept to a minimum, in two ways. First, a separate
26 emergency supply of drugs that might be required is
27 usually maintained in a small locked cupboard elsewhere
28 in the hospital and the person in charge of the night
29 service can gain entry to these supplies. Secondly,
30



1 where a pharmacist is on staff, he may be called to
2 the hospital in an emergency. In the large cities,
3 all-night retail pharmacies often are in a position to
4 supply a needed item in the event it is not available
5 in the hospital stores.

6 Some drugs require specialized storage
7 facilities, for example, biologicals which must be
8 refrigerated. Some drugs deteriorate at a predictable
9 rate, hence, they must be used or replaced regularly.
10 A number of items such as ether and alcohol are inflammable
11 and where purchased in bulk should be stored in a fire
12 proof location with adequate ventilation to the outside.
13 Poisonous materials must be distinctively packaged,
14 labelled and kept in a locked cupboard. The main
15 narcotics supply must be stored in a vault or safe while
16 narcotic prescriptions on the ward must be kept in
17 locked cupboards or drawers. These references reflect
18 some of the considerations which are attendant upon
19 providing storage for hospital drug supplies, and the
20 pattern followed is a typical one.

21 Regarding the question of inventory: We
22 have already indicated that the constituent items in an
23 individual hospital drug inventory will vary somewhat
24 according to the size of hospital and type of patient
25 treated, and, according to the preferences of the
26 medical staff. We have also referred to the fact that
27 quantities purchased will vary depending upon such factors
28 as the availability of storage and location of the
29 hospital. The rates of usage, the known perishability
30

1 of certain items, and similar considerations likewise
2 will affect the amount of items stocked. All of these
3 bear upon the size of the inventory carried in addition
4 to any price consideration.

5 Physical inventory-taking is done by all
6 hospitals on at least a yearly basis, and many do
7 spot checks periodically. Perpetual inventories are
8 not necessarily maintained since in the opinion of many
9 hospital authorities the results do not warrant the
10 volume of work entailed. In taking physical inventory,
11 members of the business office are usually pressed into
12 service, with the pharmacist or other qualified
13 persons acting in an advisory capacity. Comparisons of
14 yearly inventory figures together with knowledge of
15 any significant changes in hospital operations which
16 might affect drug inventories enable the administrator
17 of the hospital to keep in close touch with the
18 department's progress.

19 I refer, Mr. Chairman, to the Canadian
20 Hospital Accounting Manual. This is really the Bible
21 of hospital accountants in Canada. That is a method
22 by which the hospitals some ten years ago arrived at
23 standard accounting practices for all hospitals, and,
24 hence, this is a very important basic document when
25 it comes to the question of accounting for any hospital,
26 and this, of course, includes drugs. I mentioned
27 earlier, when I used the percentage distribution of
28 costs, that is it is a little difficult to definitely
29 take gross figures and say these are drugs dependent
30



1 exactly in the terms of, say, the definition of drugs
2 in the Pharmacy Act. I draw your attention that there
3 is on Page - I am quoting from Page 132 of the Manual
4 now, under the heading of "Drugs", which says, and
5 this is an interpretation of what will be charged,
6 invoices for certain items that will be charged under
7 the heading of "Drugs", and this definition reads:

8 "Drugs, medicines, chemicals, anaesthetics,
9 oxygen, intravenous solutions, anteseptics,
10 etcetera, dispensed by prescription or otherwise,
11 which are not used in patient service departments
12 of the hospital, Section 4. In small hospitals
13 it might not ~~be~~ be necessary to have more than
14 one account for drugs, etc., but for larger
15 hospitals, it would be advisable to segregate
16 drugs from anaesthetics and oxygen, thereby
17 insuring more adequate control of these expenditures."

18 And then it goes on to say:

19 "A more detailed analysis of this type of expense
20 can be obtained by the classification given here
21 below:

22 Drugs and medicines,
23 Narcotics,
24 Medicinal spirits,
25 Anaesthetics,
26 Oxygen,
27 Intravenous solutions."

28 So that I draw that as a parallel to the
29 earlier definition of pharmacy and indicate that this
30



1 is the key to some of the figures which were quoted
2 by Dr. Urquhart yesterday, and which I have used
3 earlier here.

4 Also, I mentioned that in accounting and
5 in accordance with the approaches of the standard
6 manual, most of the hospitals work on what is known
7 as the point accounting and they work on classification
8 of expenses by volumes, rather than, perhaps,
9 classification of expense for an individual item as
10 purchased. That is the total expense, say, of a
11 ward, rather than just of drugs for the whole hospital.
12

13 -

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1 Drugs are recorded in the books of the
2 hospital at cost price. I would refer to that as
3 being the invoice paid price. As has already been
4 indicated, individual charges for drugs to patients
5 no longer are applicable under our present system of
6 embodying drug costs in the all-inclusive rate. However,
7 for statistical and control purposes hospitals may
8 provide their own accounting devices to keep track of
9 their drug usage by department and/or by category of
10 drug used.

11 Hospital budgets must be examined by the
12 Ontario Hospital Services Commission in order that a
13 rate may be set for each hospital and the estimates of
14 drug expense, among many others, for the ensuing year,
15 come under scrutiny at such a time. I might say this
16 is only after, of course, these estimates have gone
17 through the hands of the various departments' heads in
18 the hospital, the Administrator and his assistant,
19 the Board of the Hospital, and their committees and
20 then hence, to the Commission for further examination,
21 so this is the way the estimated costing of the hospitals
22 is done.

23 Apart from the control which continues to be
24 exercised by the hospital itself from its records and
25 intimate knowledge of its patient load and drug
26 requirements, there is a second over-all element of
27 control in operation through the budget-approval system
28 of the Commission.

29 If we can consider accounting in a still broader
30



1 sense, the Board of Directors of the Ontario Hospital
2 Association have approved the participation of
3 representatives of the Association on a joint committee
4 with representatives of the Ontario Medical Association
5 for the express purpose of developing a manual of
6 procedures on the formation of "utilization committees".
7 In essence "utilization" can refer to a number of
8 aspects of hospital operation including admission and
9 discharge requirements, but it can be stated at this
10 time that the utilization of drugs will be one of the
11 considerations in the discussions to be held. It is
12 the mutual hope of both our Associations that a useful
13 publication can thus be developed as a form of reference
14 for both hospital administration and their medical staffs
15 in the interests of maintaining sound and effective
16 hospital operation for our communities.

17 STANDARDS

18 This presentation would be incomplete were
19 we not to refer as well to standards that have been
20 developed in relation to the accreditation service
21 available to hospitals 25 beds and over through the
22 Canadian Council on Hospital Accreditation. There are
23 additional eligibility requirements for accreditation,
24 but it is not thought essential that these be elaborated
25 on here.

26 In other words, we are going to limit this
27 only to the question that the Committee is looking at
28 at the moment.

29 We would like to indicate first, in very
30



1 general terms, what this accreditation programme is,
2 according to the Council's own description of its role:

3 " The Canadian Council on Hospital Accreditation
4 is the body officially authorized by federal
5 charter to conduct an accreditation programme for
6 Canadian hospitals.

7 The accreditation programme is voluntary.
8 Accreditation is not compulsory either on the
9 part of the hospital or the accrediting body.
10 It is not licensure. It is not governmental
11 enactment. It is a voluntary effort sponsored
12 by the Canadian Council on Hospital Accreditation
13 in co-operation with governing boards, adminis-
14 trators and medical staffs of hospitals to improve
15 the quality of patient care."

16 In this sense, the accredited hospital or
17 accreditation for the hospital begins to assume the
18 significance of Hallmark on silver and things like that.
19 I might say that this question of accreditation is
20 an international movement; it is functioning in the
21 United States as well as Canada. Both of us have
22 groups who work from very, very similar standards and
23 have a close relationship.

24 According to the 1960 edition of the Canadian
25 Hospital Directory, 92 hospitals in the Province of
26 Ontario are accredited and it may be of interest,
27 therefore, that these hospitals at least are known
28 to be meeting the following minimum standards of
29 the accrediting agency, insofar as hospital pharmacies
30



1 and drug rooms are concerned:

- 2 "(a) There shall be a pharmacy directed by a
3 registered pharmacist or a drug room under
4 competent supervision.
- 5 (b) Facilities shall be provided for the storage,
6 safeguarding, preparation, and dispensing of
7 drugs.
- 8 (c) Personnel competent in their respective duties
9 shall be provided in keeping with the size
10 and activity of the service.
- 11 (d) Records shall be kept of the transactions
12 of the pharmacy, and correlated with other
13 hospital records where indicated. Such
14 special records as are required by law shall
15 be kept.
- 16 (e) Drugs dispensed shall meet the standards
17 established by the Canadian Formulary, British
18 Pharmacopoeia, United States Formulary and
19 New and Nonofficial Remedies and the drugs
20 dispensed shall be subject to periodic review
21 of a pharmacy committee of the medical staff.
- 22 (f) There shall be an automatic stop order on
23 dangerous drugs."

24 Before leaving the subject of standards we
25 wish to make note of the fact that hospital pharmacies
26 do not come within the purview of The Pharmacy Act of
27 this province as do the retail pharmacies, a situation
28 which has of recent date been the subject of discussion
29 between this Association and the Ontario College of
30



1 Pharmacy. This is a circumstance of very long stand-
2 ing in this province and one on which we do not feel
3 any precipitate action should be taken. There are
4 a number of factors involved, not the least of which
5 is the impracticality of a full time pharmacist on the
6 staff of every hospital, a number of which do not
7 have the volume of work to sustain such a professional
8 person, even if available. On the other hand, certain
9 alternative arrangements are possible and the entire
10 situation is receiving attention at the present time.

11 In concluding this presentation, we would
12 like to stress the relationship and co-operation that
13 exists between the Ontario Hospital Association and
14 the hospital pharmacists of this province. As was
15 indicated earlier, we have a pharmacy section within the
16 constitutional structure of the Association, and each
17 fall at our annual convention this section presents an
18 educational programme of excellent quality which not
19 only pharmacists, but other hospital delegates, may
20 attend. We have occasion, from time to time to
21 discuss matters with the officers of this section, and
22 we believe that in the expanding programme of our
23 Association continuing benefits should accrue from this
24 relationship.

25 This Association also enjoys a harmonious
26 relationship with the Ontario College of Pharmacy and
27 a number of informative meetings have been held with
28 representatives of that organization on matters of mutual
29 interest. Last year a joint committee was formed
30



1 comprising representatives of both organizations for the
2 express purpose of discussing hospital pharmacy matters
3 in general and pharmacy services in the smaller insti-
4 tutions in particular. We regret that it has not been
5 possible to date to establish meetings on a regular
6 basis, but some ground work has already been laid and
7 we are looking forward to a resumption of our discussions
8 in the interests of our representative memberships and
9 the ultimate objective: the best possible care of our
10 hospitalized citizens.

11 Mr. Chairman, this is the formal part of
12 our submission. As indicated earlier, we have here
13 attempted to sketch in general terms some of the
14 hospital operations, and some of those which we felt
15 were very significant as far as the main setup of
16 this Committee was concerned, but as indicated earlier,
17 we would say, as we always have sir, that we would
18 be willing to co-operate with the Committee and provide
19 any additional details on the facts or figures that
20 you consider necessary.

21 THE CHAIRMAN: I would have to say, Mr.
22 Martin, that this is a very excellent paper dealing
23 with this subject matter, and especially bearing in
24 mind the fact that you are under no instructions as to
25 the material to be covered.

26 I have one or two observations which I would
27 like to make. It would appear quite clear from what
28 we have hear to date, that the establishment of the
29 Ontario Hospital Services Commission and its operation
30 has had a marked affect on the accounting methods of



1 hospitals in the province.

2 MR. MARTIN: Yes, in the sense of a
3 change of the whole manner in which the services of
4 a hospital are merchandised to the public, I would
5 say yes, and in the way that these records have had
6 to be changed accordingly.

7 THE CHAIRMAN: It certainly has lead to a
8 greater degree, if not complete uniformity of
9 accounting procedures.

10 MR. MARTIN: Yes, although I would say,
11 as I say our whole accounting manual was developed over
12 ten years ago, and our reporting annually to the
13 Department of Health before the creation of the
14 Commission was in line with our standard accounting at
15 that time.

16 THE CHAIRMAN: There have been a couple
17 of references to your definition of cost of drugs.
18 So we will understand each other, I use the word "cost"
19 in this instance in the sense of dollar cost, and the
20 amount which is chargeable to, or recoverable by the
21 hospital from the O.H.S.C. Your definition, as I
22 understand it, is paid invoice amount.

23 MR. MARTIN: Perhaps my definition, Mr.
24 Chairman, was restrictive in the sense of a definition,
25 but I would also have to add that the additional
26 cost of overhead, including salaries of pharmacist's
27 staff and all the rest of it, would go into the
28 operation of pharmacies, which is also recoverable,
29 but they would be in a different heading.
30



1 THE CHAIRMAN: Under a different heading?

2 MR. MARTIN: That is right.

3 THE CHAIRMAN: That is what I wanted to
4 establish. In addition to, shall we say, the
5 allowance under a different heading for the pharmacist's
6 salary and his staff and the overhead items of space
7 and light, heat, and so on, is there any adjustment
8 of the cost factor by the addition of any percentage
9 which would lead to a figure higher than your invoice
10 price which is recoverable from the Commission?

11 MR. MARTIN: In the sense that the
12 Commission's payments are based purely on money that
13 has been spent, in the actual expenditures that are
14 represented either by, or can be backed up by invoices
15 or can be backed up by payrolls, I would say no.
16 That is the item on which the per diem rates are
17 established, except that there are within the
18 structure, and in arriving at the formula which the
19 rates of the Commission is arrived at, they do take
20 back credit for certain amounts, which may be recoverable
21 by the hospital for such things that are not covered
22 by the Commission as benefits; in this sense, I have
23 already outlined the question of the out-patient
24 clinics and things that go into that.

25 THE CHAIRMAN: But, the actual dollars
26 under the heading of "Drugs" which a hospital recovers
27 from the Plan, is based on what is actually spent?

28 MR. MARTIN: That would be actually what
29 is spent. That would be subject to the audit in the
30



1 sense of our normal audit, and all hospital books
2 have to be audited annually by the Public Accountant
3 and a certificate to that effect is attached to the
4 statement which is submitted to the Commission.

5 THE CHAIRMAN: Then the component part for
6 drugs which is included in your daily bed rate, would
7 be adjusted to the actual at the year end?

8 MR. MARTIN: That is correct, Mr. Chairman.
9 We have talked about budgets. Budgets in any
10 business are merely estimates of cost. When you are
11 estimating some eighteen months in advance, it is
12 very difficult to know, and in our business especially,
13 it is particularly difficult to know.

14 These are originally based on what we
15 estimate our expenses are, but there is provision
16 then for adjustment to actual expenses at the close
17 of the business year.

18 THE CHAIRMAN: There is reference to your
19 discussion about this joint effort, a voluntary
20 effort by the Canadian Council on Hospital Accreditation.
21 You state that the first edition of the Canadian
22 Hospital Directory shows 92 hospitals have an
23 accredited status. Now how many would be eligible
24 for accredited status?

25 MR. MARTIN: I wouldn't have that figure
26 right off hand, Mr. Chairman, because, perhaps,
27 I might say, at the moment, special arrangements
28 have to be made for accrediting processes, say of
29 the psychiatric hospitals, such as the Ontario
30

1 Hospitals which have not yet been developed. All
2 hospitals under twenty-five beds would not be eligible
3 and there are some special problems in relation to
4 convalescent, chronic hospitals.

5 This would be a matter of definition. I
6 couldn't give you the answer on it off hand.

7 THE CHAIRMAN: How long has this organi-
8 zation been in effect?

9 MR. MARTIN: The Canadian Council on
10 Hospital Accreditation is now about two years old,
11 Mr. Chairman. It had its predecessor, the Joint
12 Council on Accreditation of Hospitals which was an
13 international organization and we have only had our
14 own Canadian programme for about two years.

15 I might say that this thing is progressing
16 with the very active support of both the medical and
17 the hospital profession, and while there are 92 now,
18 this programme is expanding and it is the incentive
19 that brings all of these up to certain standards, and
20 it is definitely involved in quality here.

21 THE CHAIRMAN: I think it is rather important
22 for us to establish at this stage of our inquiry the
23 daily bed rate which is charged to that 6% portion of
24 our population which is not covered by the Hospital
25 Plan, and we have had some evidence so far stating,
26 or inferring, that the daily rate charged to non-
27 insured persons was the same as the daily rate charged
28 to the scheme by an insured person?

29
30



1 MR. MARTIN: Yes.

2 THE CHAIRMAN: Now, are you in a position
3 to state the prevalence or the extent to which that
4 exists in the hospitals which are not of government
5 ownership? Is it a general rule? Can we say that
6 all of them - if you have an \$18.00 all-inclusive
7 rate under the scheme, can we say how many hospitals
8 throughout Ontario charged a non-insured person
9 \$18.00?

10 MR. MARTIN: This would be applicable,
11 Mr. Chairman, to all those hospitals, - let me
12 put it this way to you: That all public hospitals,
13 and this would in the sense be the second category
14 referred to in our brief, by far the majority of
15 hospitals, this would be so in that hospital. It
16 would not matter whether I walked in there and
17 occupied a bed in that institution and had paid my
18 premiums in the hospital insurance plan, and
19 consequently, they would be billed then for the
20 \$18.00 cost, whether prepaid hospitalization, or
21 whether you walked in, cost the same. It does
22 not matter if you decided not to insure yourself, your
23 bill which you collect at the front office of the
24 hospital would be paid at the same rate that my bill
25 would be paid by the Commission.

26 The exception here, might be in the area
27 of private hospitals. The private hospitals are a
28 little different. They have to enter into agreements
29 with the Commission, and they do retain certain rights,
30



1 I believe, under that arrangement of charging within
2 the agreement they have with the Commission. In
3 other words, they are not restricted by law, the
4 same way the public hospitals are.

5 Do I make myself clear, or am I muddy?

6 THE CHAIRMAN: Would you be able to tell
7 us what types of hospitals there are in Ontario
8 which might not charge the same as the rate for an
9 insured person?

10 MR. MARTIN: The types of hospitals,
11 Mr. Chairman, would be - and as a rule, they are
12 very small - they are as a rule hospitals that are
13 operated possibly for specific purposes. They are
14 classified. They are all named in the last report
15 of the Hospital Services Commission, right at the
16 back, and they would be mostly or very frequently
17 a type of hospital that may be catering to maternity
18 work, or more than likely, they are just a grade
19 above a nursing home where they provide a great deal
20 of convalescent care, perhaps.

21 THE CHAIRMAN: Would they be privately
22 operated organizations?

23 MR. MARTIN: Yes, they are the privately
24 operated institutions, but you can take it for the
25 record, Mr. Chairman, that public hospitals - and
26 they are listed in the report of the Hospital Services
27 Commission, which will be available to you as Class
28 A, B, C, D, E, F, and G, and all those hospitals
29 in there, you can take it as gospel, that those
30



1 hospitals will be charging identically the same rates
2 to the public, whether they be insured, whether they
3 be covered by the Workmen's Compensation Board, or
4 whether they be paying the bills themselves.

5 MR. WREN: You say, "any person", do
6 you mean by that an Ontario citizen or any individual?

7 MR. MARTIN: Any individual, Mr. Wren.

8 MR. WREN: Any person from a foreign
9 country would pay the same?

10 MR. MARTIN: That is right.

11 THE CHAIRMAN: I raised this question to
12 you because I had in mind, in recent years, but
13 before the Hospital Services Commission was in operation,
14 situations where some hospitals apparently had
15 special rates for Workmen's Compensation Board cases,
16 and when a person went in, the first question they
17 would ask would be, "Is it a Compensation Board case?".

18 In that situation, the patient has an
19 election. The patient in the case I have in mind,
20 said, "I do not know how I am going to elect, but I
21 have the money, and I would like to pay my bill."
22 He was unable either to get a bill or to pay his bill.

23 It seemed a bit unusual to some of us, at
24 the time the cash paying patient should be charged at
25 a higher rate, than if he had elected to go under
26 some other form of coverage.

27 MR. MARTIN: Mr. Chairman, I would only
28 say this in answer to the observation, that this
29 probably would not have quite the effect in the latter
30



1 years, because we in the Workmen's Compensation
2 Board word out an arrangement, whereby they did just
3 about pay the same rate as the public did.

4 Probably, the observation should be made
5 that under the legislation under which the Workmen's
6 Compensation Board functions, they have the right
7 to tell the hospitals what they will pay for the
8 services. The hospitals have not the right to say
9 what they will charge.

10 This, I think, puts it into focus for you,
11 that the hospitals through their boards, would have
12 to determine the amount of money they needed to carry
13 on. But, at one time, the Board said, "We will
14 only give you x number of dollars" - and I am going
15 right to the extreme here - but this has disappeared
16 for the past number of years from the hospitals
17 arranging to sit down together with the Board and
18 work this out, which they have done very well.

19 THE CHAIRMAN: This has now been equalized?

20 MR. MARTIN: The Board pays the rate
21 established by the Commission, so that there is no
22 difference.

23 THE CHAIRMAN: That is what I say. It
24 has been equalized?

25 MR. MARTIN: Equalized, yes.

26 MR. SUTTON: On Page 6, when you were
27 discussing the rate structure of the hospital services,
28 are there any hospital services left out of this
29 inclusive rate structure?
30

1 MR. MARTIN: Mr. Sutton, through Mr.
2 Chairman, the Hospital Insurance Plan is a basic plan,
3 and what we refer to, provides the cost up to
4 standard ward, including all the services.

5 There would be an additional charge if the
6 patient elected to occupy semi-private or private
7 accomodation, and there might be certain extra charges
8 for what we call "non-hospital services"; that is,
9 for somebody sending down and ordering flowers from
10 the flower shop, or in some cases, personal telephone
11 service, personal television in the room, and things
12 like that. They would be additional.

13 Basically, all the services required for
14 the medical treatment of the patient, I would say,
15 would be covered.

16 MR. TROTTER: Mr. Chairman, I would like
17 to ask Mr. Martin, about this question of the buying
18 of drugs on Page 12 of your brief. You mention a
19 large hospital possibly getting a lower rate by virtue
20 of their greater purchasing power, and the possible
21 advantage to drug firms of having their products used
22 in circumstances where extensive clinical research
23 and application is taking place.

24 Do you think the hospitals might possibly
25 obtain drugs more cheaply if the Hospital Association
26 had a central agency, or if the government had a
27 central buying agency?

28 MR. MARTIN: This is a question which we
29 have under very careful consideration at the present
30



1 time. It was interesting, I was reading the
2 minutes of our Association back in the early 1920's
3 the other day, and I noticed this question had been
4 looked at, at that point.

5 What we have to recall here - and this is
6 why I cannot give you a "yes" or "no" answer,
7 because groups buying or the placing of orders to be
8 delivered to individual stations, properly could put
9 at the disposal of the small hospital, the purchasing
10 power of a group, rather than a distinct individual.

11 I have made the point that these hospital
12 units that have been developed, of course, are
13 really community corporations, you see, and there has
14 been a desire all along the line to keep them as such.
15 So as long as the element of group buying is involved,
16 you get the question - as has been demonstrated by
17 the Ontario Hospitalization - you have to get into
18 warehousing and many things. This means, the
19 purchases have to go to a central spot, and be
20 warehoused out, and these things increase the cost as
21 against the person buying drugs from the agent or
22 the manufacturer.

23 I would not be prepared to say if that would
24 be so, but as a general observation, it would seem
25 logical that the purchasing on a collective basis
26 would effect some savings.

27 This has to be subject to some careful
28 investigation, which we are doing at the present time.

29 MR. TROTTER: In the various meetings that
30



1 hospital people might have, does this subject come
2 up very often, the question of central buying?

3 MR. MARTIN: It does not come up with
4 any ~~forces~~ or very frequently, Mr. Trotter.
5 But as I say, because of the terrific emphasis that
6 we are facing with relation to cost, and our complete
7 awareness of the growing costliness of hospitalization,
8 we are looking at every angle, and this is one of
9 the things that we are giving careful attention to
10 at the present time.

11 MR. TROTTER: If I may, there is one
12 other question, on Page 12, of your brief having to
13 do with the patient. While the patient is in the
14 hospital, he or she can obtain drugs, but once the
15 patient is discharged from the hospital, he cannot
16 order them under the scheme.

17 Could it be the case, that some people might
18 not be able to afford these drugs once discharged
19 from the hospital, and that they eventually return
20 to the hospital because of the fact, that they cannot
21 get them once they leave the hospital, and once again,
22 they might fall ill, and will have to go back to the
23 hospital, and your costs would go up?

24 MR. MARTIN: I suppose your observation
25 might be valid in some cases, but I think it would
26 have to be tempered with the situation, for instance,
27 I mentioned the out-patient clinic.

28 Those of you who are in Toronto and the
29 larger centres, know that when a person is discharged
30



1 from a hospital as an in-patient, they are referred
2 back to the out-patient clinic, and in this way,
3 they continue to get their treatment and drugs, as
4 Dr. Brien mentioned yesterday.

5 On top of this, we would remember that
6 through social legislation of the Province, there is
7 a plan of what we call "medical relief". That is for
8 people of low incomes, those on old age pensions,
9 relief cases, mothers' allowances, the blind,
10 disabled, and so on. Those people are provided
11 through the Province and through an arrangement with
12 the Province for medical relief.

13 That also includes some provision for drugs,
14 so that with all these programmes, I think it is
15 very difficult to make a general observation on your
16 specific observation.

17 MR. TROTTER: As I understand it, the
18 people who would not be covered would be the average
19 citizen, unless you applied for relief, or old age
20 pensioners, and you would still be on your own.

21 MR. MARTIN: You would be on your own.

22 MR. BOYER: Following that up, I have
23 just a small point in connection with the sale of drugs
24 to out-patients. You would be selling them,
25 sales tax exempt in the hospital, but these would
26 not be supplied, sales tax exempt, with the result
27 that eventually, it would increase the cost nine to
28 ten percent, or I suppose it would be eleven percent
29 higher on account of the sales tax, is that right?
30



1 MR. MARTIN: The services are not covered,
2 Mr. Chairman, by the Commission. At this point the
3 cost becomes a little different in its definition
4 than the invoice. At this point the hospitals have
5 to try to meet their costs.

6 Because there cannot be a nominal charge
7 put on these drugs, if the patient cannot afford to
8 pay for it, very frequently, in my experience, I
9 have seen in the evaluation of the people, the social
10 service people, because of the desire of some people
11 just to pay a little, I have seen us issue \$4.00
12 worth of drugs for 25 cents.

13 Things like this occur and this is a service
14 which is not predominantly related to cost. Hospitals
15 do have some charges. Dr. Brown did not mention it
16 yesterday, but he might have said that the City of
17 London has to pay out the balance of money for the
18 Victoria Hospital in London. Somebody has to pay
19 money to keep the thing going.

20 THE CHAIRMAN: Would it follow that you
21 are suggesting their objective would be -

22 MR. MARTIN: Would be to get the cost.

23 THE CHAIRMAN: To break even?

24 MR. MARTIN: To break even, which would
25 include the overhead and some of these other things.
26 But these drugs, even at that, would be priced at
27 a definite percentage less than what might be the list
28 price.

29 THE CHAIRMAN: But it would also follow,
30

1 that if some were sold on a carefully devised basis
2 with token payments, that by the same token, somebody
3 else might be paying \$4.50 or \$4.75?

4 MR. MARTIN: Yes, this could happen,
5 but it would be the unusual case, because in this
6 case we are dealing primarily with people in the low
7 income brackets.

8 THE CHAIRMAN: Then the actual measure of
9 what we are talking about, would depend upon the
10 ultimate result of the pharmacy operation for the
11 out-patients?

12 MR. MARTIN: That is right.

13 THE CHAIRMAN: Which you no doubt have to
14 look at, I presume?

15 MR. TROTTER: I would like to ask Mr.
16 Martin in his opinion, what influence the so called
17 "detail men" from the drug companies have on the
18 purchase of drugs by the hospitals?

19 MR. MARTIN: I think if we go back here
20 to the basic premise that hospitals in the final
21 essence are really the middle men in this deal.
22 The fact might not be admitted in the hospital, but
23 it could have an effect on the detail man on the
24 doctors operating and practicing in that hospital.

25 If a man is detailed to a product which seems
26 particularly pertinent and efficacious for the
27 treatment of that particular patient and the disease
28 that they are suffering from, then obviously, the
29 efforts of the detail man might be required in that
30



1 the doctor would want to use that product.

2 MR. TROTTER: When a hospital buys drugs,
3 do you find that the officials of the hospitals are
4 under much pressure, under much sales pressure from
5 the various companies?

6 MR. MARTIN: Actually, the relationship
7 between the hospitals and the detail man, as far as
8 the hospital is concerned, is more in the nature of
9 what was referred to here yesterday by Dr. Brien,
10 as the governing agency of the products that are
11 available, because these people must know when a
12 prescription comes down for something, they must
13 know immediately what this is all about, what this
14 is for, its background and component parts and so on,
15 so that the detail man would have a function of not
16 only keeping up-to-date the pharmacist in the hospital,
17 but the pharmacist himself on the directions and the
18 observations that are coming out of the Pharmacy
19 Committee would not have the sole right of giving
20 business to a detail man, just because he called on
21 him and said, "You must have this product."

22 -

23 -

24 -

25 -

26 -



1 THE CHAIRMAN: That would mean he would
2 be doing a service not called for?

3 MR. MARTIN: That is correct.

4 THE CHAIRMAN: A pharmacist, when buying,
5 would have to replenish his stock as required?

6 MR. MARTIN: That is correct.

7 MR. WHITE: Mr. Chairman, I have some
8 questions . . .

9 THE CHAIRMAN: Yes -- in just a moment.
10 Have you any knowledge, or are you able to make any
11 statement about the methods of purchasing which pre-
12 vail in your membership?

13 MR. MARTIN: Well, sir, I think we could
14 indicate that they follow along the normal business
15 practice. As I said earlier, you eventually come to a
16 sort of a stock inventory or a stock list of the drugs
17 that are being called for or which are being used in your
18 institution. You have some idea as to your requirements
19 in periods of time and, therefore, the ordering or
20 purchasing would largely be done through one or two
21 ways. If they are what you might call items that are
22 in common use, particularly in our larger hospitals where
23 they have volumes involved, they very frequently give a
24 tender and estimates for a period of time will be made
25 up and then they will be prepared and they will go out
26 to be tendered on by the various groups and, ordinarily,
27 depending on the standard of quality and that is largely
28 determined by the reputation of the house supplying, they
29 are purchased on the basis of price.
30



1 THE CHAIRMAN: We will, no doubt, come to
2 more specific examples of this at a later stage?

3 MR. MARTIN: That is correct. That is the
4 practice, as I have tried to point out to you, with
5 240 agencies operating independently, making up the
6 spectrum of practices.

7 MR. WHITE: Mr. Chairman, at the top of page 6,
8 the brief says:

9 ". . . the Board has the right not to accept

10 "medical practitioners on the hospital staff . . . "

11 Am I correct in thinking that a doctor does not have to
12 be on staff to use the facilities of a hospital, Mr.
13 Martin?

14 MR. MARTIN: This would very largely
15 depend on the by-laws of the individual hospital, because
16 this is the legal background to this. A hospital may
17 have provision within its by-laws for extending
18 courtesy privileges to a doctor, but, by and large, the
19 practice is that if a doctor is going to use a hospital, they
20 become a member of its medical staff, because in so
21 doing, they have committed themselves to conform to the
22 rules and regulations and by-laws of the hospital; so
23 that it is a two-way street in this way, Mr. White,
24 that there is a desire to co-operate in this, but I
25 would say that there could be provision in individual
26 hospital by-laws to extend what might be termed courtesy
27 privileges to a doctor without actually having him on
28 the staff.

29 MR. WHITE: Now, Victoria Hospital, the
30



1
2 Governing Board announced several years ago that the
3 facilities of the hospital would not be extended to
4 those doctors that carried on fee-splitting and that
5 was appealed and I think the Board was upheld?

6 MR. MARTIN: That is correct.

7 MR. WHITE: Do the hospitals seek to control
8 the abuse we have heard about of pharmacists, that is
9 of retail druggists paying commissions on prescriptions
10 to a doctor who prescribed . . . ? I don't know how
11 great a problem it is in the Province, but I am
12 wondering if the hospitals have given any thought to
13 that aspect?

14 MR. MARTIN: Well, Mr. Chairman, beyond a
15 general observation that I would say that ethics is a
16 very definite part of what is interpreted as being a
17 requisite of hospital medical staff privileges, this
18 would only come in that area, I think, and would be
19 judged as to the ethicalness of such a practice. But,
20 to my knowledge, the point has never come up.

21 MR. WHITE: This would add to the cost of
22 drugs if it were being done? That is why I asked
23 the question.

24 MR. MARTIN: I don't know that I am competent
25 to answer that question yes or no.

26 MR. WHITE: On page 7, reference is made to
27 the National Formulary. Is that a Canadian publication,
28 or where would that originate?

29 MR. MARTIN: That, I believe, is an American
30 Publication, Mr. White.



1 MR. WHITE: The Canadian Formulary mentioned
2 below; who would put that out? Is that put out by
3 a hospital association?

4 MR. MARTIN: No, no. I can't tell you that
5 just offhand.

6 MR. WHITE: Is it an official body, or is
7 it a private organization; do you know?

8 MR. MARTIN: I do not know.

9 MR. WHITE: On page 11, reference is made
10 to so-called "generic houses". Can you explain that
11 further? What does that mean?

12 MR. MARTIN: I think, Mr. Chairman, in this
13 context, it refers to certain drug firms who would be
14 merchandising drugs not as brand names, because they
15 probably aren't in the business of manufacturing, but
16 this could be purchasing from the manufacturers and
17 merchandising them under the generic names.

18 MR. WHITE: Well, I was told there were
19 20 major drug houses in the States. Would some portion
20 of those be generic houses, or are they all brand . . .

21 MR. MARTIN: It would depend on what the
22 context would be, I think, Mr. White. It would
23 depend -- usually, I suppose, of that number I would
24 more than think, Mr. Chairman, to my knowledge of what
25 is behind, I mean behind the observation of the 20, it
26 would sound more to me as though that probably it was
27 in relation to people who do actually manufacture the
28 products themselves.

29 MR. WHITE: Now, the Chairman sought more
30



1 clarification of the costs, the so-called invoice price,
2 and I am still not clear on this. Yesterday, Dr.
3 Urquhart told us that the cost of drugs in 1958 was
4 approximately 75 cents per patient day and in 1959 this
5 figure was 84 cents per patient day, and he indicated
6 that these amounts included space charges and certain
7 labour charges.

8 MR. MARTIN: I don't know whether Dr.
9 Urquhart is in the audience, but I would interpret
10 that, from my own knowledge of the accounting records
11 and the knowledge that our breakdown on page 7, and
12 if you look -- if you think back to the presentation
13 being used on Tuesday, where he provided a cost break-
14 down for 1959 at St. Michael's Hospital, his estimate
15 of that 75 or 80 cents represents -- you could go back
16 and you could pick out in this brief all the hospitals
17 in the Province that would total that amount of money
18 for that year.

19 MR. WHITE: On page 12, in the middle of
20 the page, there is the statement:

21 "Out-patient services are not at present benefits
22 "under the Hospital Services Commission Act",
23 and then you have modified that by saying that certain
24 emergency services are provided. Would you elaborate
25 on that?

26 MR. MARTIN: Yes. I mentioned that because
27 we have some difference in terminology or understanding
28 of terminology when we are talking about out-patient
29 clinics and the further services and these are only
30



1 provided -- those are what we call public out-patient
2 clinics. These are only provided in the hospitals
3 in the Province. But, also, every hospital provides
4 a certain amount of what we call ambulatory or walk-in
5 walk-out service for a patient who does not need to
6 go to bed and this includes the question of setting of
7 fractures, very minor surgical procedures, emergent
8 medical accidents and so on and this type of emergency
9 type of things, the sort of private, what I would
10 refer to as the ambulatory private service, because the
11 clinics are restricted with a means test of a person,
12 really. But, any of us can get emergent service or
13 certain minor service at a hospital on an out-patient
14 basis and these emergent services and certain minor
15 surgical and medical services are available as benefits
16 to the plan.

17 MR. WHITE: So, there would be some free
18 drugs issued in that?

19 MR. MARTIN: There would be some drugs
20 issued in that, yes. Incidentally, of course, the
21 hospitals are paid for this emergent service, in
22 addition to the per diem rate. It is a different type
23 of payment.

24 MR. WHITE: That is a new development, isn't
25 it?

26 MR. MARTIN: No. This has been in since
27 the plan was introduced, Mr. White.

28 MR. WHITE: Has it been broadened recently?

29 MR. MARTIN: No. I don't think that it has
30



1 been broadened. It has been only as interpretation
2 might apply to it, Mr. White.

3 MR. WHITE: Further down the same page,
4 it says:

5 "Thirdly, drugs are supplied, on doctors' orders,
6 "to out-patients."

7 Those drugs would be sold; am I correct in thinking
8 that?

9 MR. MARTIN: Well, I would have to say that
10 they can either be sold or they can be given, depending
11 on the status of the individual.

12 MR. WHITE: Well, if they were sold, would
13 you know what price was charged? Would it be the same
14 as a retail drugstore, or something less than that?

15 MR. MARTIN: I think I tried to answer Mr.
16 Sutton on that question, or Mr. Trotter, by saying
17 that there would be an attempt made if the patients
18 were able to pay the recovery cost, the base cost of
19 the drug, at least whatever might be a nominal charge
20 for the overhead of the persons who had to handle this
21 and the services which go into it. I would say that that
22 would not be the retail price.

23 MR. WHITE: Do you mean a doctor is free to
24 prescribe drugs to be drawn from the hospital, for his
25 patients?

26 MR. MARTIN: In the case of these out-
27 patient clinics, they are, yes; because this is a
28 service, really, that is provided to our low-income
29 groups of people.
30



1 THE CHAIRMAN: Is there not a qualification
2 to your definition of an out-patient clinic?

3 MR. MARTIN: Yes.

4 THE CHAIRMAN: Does it not mean treatment to
5 a patient who was formerly an in-patient in the
6 hospital and is now convalescing for the equivalent, out-
7 side the hospital?

8 MR. MARTIN: This could apply also, sir, to
9 the general practitioner in an area, if he came up
10 against a case where a patient required the services of
11 a consultant specialist and he knew that he wasn't in a
12 position to pay for this type of thing and all the
13 diagnostic work that would be required, this person
14 might not need to go to bed and he could be referred to
15 these clinics for further work. It serves both pur-
16 poses. Both of the sets of them are covered in the
17 clinics.

18 MR. WHITE: Well then, does this third
19 method of distributing drugs there refer only to the
20 18 hospitals that have clinics? I gathered that this
21 applied to all hospitals.

22 MR. MARTIN: No. I am referring only there
23 to the out-patient department as such -- in the 18
24 hospitals that they have what we call organization
25 out-patient clinics.

26 MR. WHITE: That third distributing channel
27 is for the clinics only?

28 MR. MARTIN: Yes -- restricted, yes.

29 MR. WHITE: Would your association have any
30



1 comparison of drug costs where local retail druggists
2 provide required items to small hospitals, as mentioned
3 at the bottom of page 12, as compared to a large
4 hospital supplying a drug? Would it be twice as
5 much?

6
7 MR. MARTIN: I must admit that we have not
8 got those figures specifically in there, so, I could
9 not make the observation.

10 MR. WHITE: Now, on page 13 . . .

11 MR. MARTIN: I might just say on that,
12 Mr. White -- May I, Mr. Chairman, make an observation
13 on that question. The problem we have here is that it
14 is that the total dollars that is spent by a hospital --
15 that would be the full answer here, because if you
16 compare those to the dollars spent in a large hospital
17 and you would have all the different types of operations
18 that were provided and you would have to take into
19 consideration so that the larger hospital could and
20 quite frequently have the very acutely ill or very
21 expensive phases of the various medical treatment they
22 give; whereas the small hospital that might be
23 doing this would never see this kind of patient, because
24 they would be referred to the larger hospital . . .

25 MR. WHITE: I was thinking of costs of
26 individual items?

27 MR. MARTIN: This is the difference. This
28 would be the difference.

29 MR. WHITE: Now, on page 13, reference is made
30 to: "Suitable arrangements are also possible for the



1 "return of obsolete or expired drugs to suppliers
2 "for credit."

3 Do I understand from that that if a hospital purchased
4 more drugs of a certain type, that they could return
5 those for a full credit at a later date and, if so,
6 would this apply to drugs that deteriorate?

7 MR. MARTIN: There would be a problem here
8 involved in the arrangements that could be made by the
9 individual hospital with the supplier and while this may,
10 as a -- I qualify everything by the general observation
11 I wouldn't say that this applies to every item. We
12 couldn't say that it applied to every item. But, by
13 arrangements and by management arrangements, by careful
14 management, there have been and there are situations
15 where if an item is not going to move out where it might
16 be moving out faster in other areas, it could be quite
17 apparent that it would be useless to keep this on the
18 shelves and in an effort to try to conserve the total
19 cost picture, these kind of arrangements could be made.
20
21
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1 MR. WHITE: I have heard, I may have been
2 misinformed, but I have heard that with the development
3 of these wonder drugs the hospitals have sometimes
4 been stuck with such drugs and cannot send them back.

5 MR. MARTIN: I think you may make this as
6 a general observation for anybody who is teaching
7 pharmacy to these people to the degree that we are
8 able to make these arrangements in certain instances.
9 I couldn't say that everything can be done this way.

10 MR. WHITE: If they are obsolete, the problem
11 is probably of taking them back.

12 MR. MARTIN: I think the point we are talking
13 about here is a certain amount of management, that
14 arrangements can be made to work this out.

15 THE CHAIRMAN: To effect a saving or to
16 avoid wastage..

17 MR. MARTIN: To avoid wastage, that is
18 correct, sir.

19 THE CHAIRMAN: That would get back to the
20 factor of the management of the hospital?

21 MR. MARTIN: Yes, the management of the
22 hospital.

23 MR. WHITE: I have got a couple more
24 questions, Mr. Chairman. On page 13 you mentioned
25 chemical analysis is not made in the hospital because
26 very often the time is not available or perhaps
27 facilities are not available. We were led to believe
28 the other day that the Ontario Hospital finds it essential
29 to test the quality of drugs from some suppliers for the
30



1 reason some suppliers do not always supply a high
2 quality product.

3 If the Ontario Hospitals, or the Department
4 of Health find it necessary to do this, I suppose
5 that the general hospitals find it equally essential?

6 MR. MARTIN: This is a good observation,
7 Mr. Chairman, and we have deliberately put it in there
8 because we wanted our position understood quite
9 clearly. We did qualify this, of course, by saying
10 that we in our purchasing programme deal only with
11 firms that we know will provide -- now, we have had
12 in general hospitals some experience -- that was
13 referred to by Dr. Brown, of people trying to pur-
14 chase certain drugs for certain people at less price.

15 We have had to reject it for the same reason
16 that we couldn't be sure of the quality, obviously, so
17 even the problems that we came up against, and I did
18 very carefully, I think, say there that the opinion
19 of the medical staff as to patient reaction to drugs
20 is also important -- this is a team effort. This is,
21 first of all, the question of what is observed at the
22 initial point, and then the question of effect.

23 You can appreciate that with 240 units, this
24 question of testing would become a very important cost
25 factor in itself for stuff that is going out, because
26 you would almost have to go in and test everything
27 that came in to every one of those different locations.
28 Now, the part perhaps that was being sent to the
29 Ontario Hospital they can bring this into a central
30



1 source and then send them out for they only have 18 units
2 to look after.

3
4 Here you have a group of people who are
5 probably in the same boat as the individual pharmacist
6 that would have to try -- so that the question then of
7 trying to test, you see, almost goes back to a
8 dependability factor on the people that are going to
9 merchandise those products, and again this point was
10 made by Dr. Brown that it is very important that you
11 have confidence in the fact that what is set out on
12 the bottle is what is actually in fact inside the bottle,
13 and hence our people, you see, would gradually reject
14 even though there might be a question of a cheaper price,
15 they would have to reject it on the basis that they
16 couldn't be sure that what was coming out was actually
17 what was being ordered by the doctor.

18 MR. BRYDEN: Of course you can't be absolutely
19 sure of that in any case, can you?

20 MR. MARTIN: You can't, Mr. Bryden.

21 MR. BRYDEN: I remember a few years ago there
22 were suppliers that were normally considered to be
23 reliable who sought to put vaccine on the market that
24 killed some people. It seems to me this testing problem,
25 or inspection problem is a pretty critical one both for
26 hospitals and for the public at large.

27 MR. MARTIN: Yes. We, of course, would be in
28 the position that anybody is. The Food and Drug Act really
29 is set up to guarantee to the public -- we are the public,
30 after all, just the same as anybody else, when you get on

1 disseminating -- the question of testing then becomes
2 rather a horrible situation.

3 MR. WHITE: They only test after it has
4 been administered.

5 MR. MARTIN: The Food and Drug people? No.
6 They have first function in this testing field.

7 MR. WHITE: I was told yesterday that they
8 carried out their testing by sampling retail druggists'
9 products. Reference was made in your brief to cost
10 price being the invoice paid price. A day or two ago
11 we were told that there was today a system of rebates
12 from drug manufacturers. If the volume got over
13 certain limits, that rebates were made at the end of
14 the year to the hospitals purchasing the drugs. That
15 would affect the invoice paid price, of course. Is
16 this a custom in general hospitals?

17 MR. MARTIN: Not to a marked degree, Mr.
18 Chairman, through you, because in most cases the
19 Department of the hospital doing the purchasing usually
20 knows, and anyway it will probably be pretty well known
21 and very frequently the basis of this from the standpoint
22 of when it is ordered is if you order 50 million of
23 these things you will get this price, so it is reflected
24 then in the invoice price you paid because you place your
25 order for that amount at that time.

26 THE CHAIRMAN: If there are some credits
27 to be gained to the general hospital ---

28 MR. MARTIN: I would prefer to refer to them
29 as volume discounts.
30



1 THE CHAIRMAN: I am thinking of the total
2 of the invoices.

3 MR. MARTIN: At the end of the year there
4 could be on certain things like intravenous solutions
5 where you wouldn't know what your total usage would be
6 and you could get cash rebates and that would go to
7 reduce the cost of that on your books because it would
8 be a direct credit to the cost of drugs.

9 MR. WHITE: Would those cash rebates refer
10 to the total dollar purchases from a particular
11 company?

12 MR. MARTIN: Yes.

13 MR. WHITE: My final question has to do
14 with a remark you made in answer to a question of the
15 Chairman. You mentioned hospital classifications
16 A, B, C, D, E, F, G. Do they relate to size only?

17 MR. MARTIN: Yes. Basically, the A
18 classification is hospitals of 500 beds and over, with
19 a teaching category. B are hospitals of 100 to 500 beds,
20 and C are hospitals of 100 beds and under, and then
21 the others come in under special classification.

22 MR. WHITE: Mr. Chairman, do you think it
23 would be worthwhile to ask the Association to provide
24 us with an explanation of those classifications and
25 perhaps listing hospitals in the Province that fall
26 into different classifications?

27 THE CHAIRMAN: Well, I have that in mind,
28 Mr. White. I think the overall picture of that
29 situation can best be supplied from a Hospital Service
30



1 Commission which is in touch with every hospital in the
2 province, but that information will be required.

3 MR. WREN: Turning to page 6, you say there:

4 "On the other hand, by inference, the Board has the
5 "right not to accept medical practitioners on the
6 "hospital staff ..."

7 How do you reconcile that with the Hospital Service
8 Commission and government policy, and other policy, that
9 a person has the right to choose his own doctor? If the
10 College of Physicians and Surgeons licensed this man as
11 a fit and proper person to practice, does that not affect
12 my right to engage him as my doctor? I am thinking now
13 of single hospital communities. What is he going to do?

14 MR. MARTIN: This could be a problem, Mr.
15 Wren. Actually, in the situation that you mentioned,
16 we never really had a real problem here, but it wouldn't
17 in any way affect your right to engage the physician of
18 your choice.

19 MR. WREN: What are you going to do if he
20 can't get you in the hospital?

21 MR. MARTIN: He, of course, then, would have
22 the problem, if he didn't have the privilege of the
23 hospital, he would have the problem of seeking out
24 someone who could get you in.

25 MR. WREN: That is very important in some
26 of these single hospital towns, because doctors very
27 jealously guard their practice sometimes and many new
28 incoming physicians find it very difficult to get beds.
29 What difference is there having the Board say to them they
30

1 wouldn't be admitted to staff?

2
3 MR. MARTIN: Of course, there would be a very
4 close liaison with the College of Physicians and Surgeons.
5 If you were sitting on a Hospital Board, you would be
6 thinking very carefully before you took the privileges
7 of the hospital from anyone so there would be very, very
8 good reasons for this so you would prefer there would be
9 close liaison of course, then.

10 MR. WREN: I know of some examples, I have
11 witnessed some examples where a physician or physicians
12 concerned, while the Board said to any incoming physician
13 while we might allow you to use the facilities of the
14 hospital, the other physician or physicians say today
15 that no beds were available because as soon as one became
16 empty, they put their own patients in it.

17 What I am getting at is this -- as I understand
18 it, from the years I was on the Hospital Board, Now,
19 the Act may have been changed, I don't know, but as I
20 understood it in those days the matron actually had the
21 final say.

22 MR. MARTIN: The which?

23 MR. WREN: The matron in the hospital or the
24 chief supervisor.

25 MR. MARTIN: Except if we think of the Act,
26 sir, we will remember that the Act states that no hospital,
27 public hospital can refuse admission of a patient, but
28 that doesn't go so far as to say they have to admit the
29 patient of the doctor that is attending them at home.
30 The patient would receive care.



1
2 MR. WRAN: It basically infringes a person's
3 right, I think, to his own physician when a licenced
4 practitioner could not have availability of the hospital
5 facilities.
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1 MR. MARTIN: On the other hand, I think
2 from your experience on the hospital board that you
3 would know that the community through these people
4 who are on the board are invested with the responsibility
5 to ensure and assure that the people who are using the
6 facilities of that hospital are competent and ethical.

7 MR. WREN: We have to rely on the College
8 of Physicians and Surgeons to tell us about that.
9 We have no way of determining that, other than through
10 them.

11 MR. MARTIN: Well, there are situations,
12 sir, where it takes time. It is a problem of
13 catching up, and when you think about the thing right
14 through, certainly it is not intended to create a
15 monopoly for anybody.

16 MR. WREN: It has happened.

17 MR. MARTIN: It is intended to safe-guard
18 the community and to discharge the responsibilities of
19 these very community-minded people.

20 THE CHAIRMAN: What you are stating on
21 that point is your observation with respect to the
22 broad picture, and that, in fact Mr. Martin, the
23 exercise of that privilege rests with the local
24 hospital board?

25 MR. MARTIN: That is right.

26 THE CHAIRMAN: Not the Hospital Association?

27 MR. MARTIN: No, we have no responsibility
28 in that regard.

29 THE CHAIRMAN: It is the local board of
30

1 any hospital?

2 MR. MARTIN: That is right.

3 MR. WREN: I realize that. I am just
4 using the statement he made here.

5 MR. TROTTER: I have one question to ask
6 of Mr. Martin.

7 I understand that a large portion of the
8 drugs purchased by the hospital is the result of
9 recommendations made by the doctors for their own
10 patients. They are anxious to protect that right
11 for the doctor, and have whatever the patient requires
12 and should have.

13 Since the inception of the government scheme
14 where the drugs are supplied to the patient in the
15 hospital under the scheme, have you noted any inter-
16 ference or any increased difficulty that the doctors
17 have had in prescribing what they want for their own
18 patients? Has the scheme made any difference to the
19 doctor?

20 MR. MARTIN: Not as far as I am aware,
21 Mr. Chairman, none at all.

22 THE CHAIRMAN: Well now, Mr. Martin, thank
23 you for your assistance. I think I can say with
24 some certainty that your organization and your member-
25 ship will be called upon for additional information.

26 At this stage of our proceedings, it is our
27 intention to adjourn sine die, as we say, at this
28 stage, but to resume in a matter of six to eight weeks.
29 It is probable that this questionnaire will be sent out.
30

1 We had in mind that this preliminary hearing
2 might in a sense be regarded as background, and that
3 stage two of the hearing would constitute a more
4 specific and detailed investigation of all matters
5 within our terms of reference applying to hospitals,
6 and having in mind, and so advising you and your
7 membership, I would expect that the Committee will
8 proceed and will announce the date of its next hearing.
9 If there is to be a questionnaire or information
10 required, it would take some time and investigation.

11 I think I might state with some certainty
12 that it will be by way of a questionnaire, to enable
13 you to provide the information.

14 MR. MARTIN: Any time you can give us on
15 that would be appreciated, Mr. Chairman. We are
16 quite willing to do it, but it is coming into the
17 summer months, and things do slow down a bit. We would
18 appreciate the time you could give us on that.

19 THE CHAIRMAN: Very well. Are there any
20 further observations or comments anyone wishes to make
21 at this stage of this hearing?

22 If there are none, I declare the hearing
23 adjourned sine die.

24
25 --- Adjourned sine die.
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K. Fryden

Select Committee on Drugs

HEARINGS

HELD AT
PARLIAMENT BUILDINGS
TORONTO, ONTARIO

VOLUME No.:

4

DATE:

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SELECT COMMITTEE ON DRUGS

Proceedings of hearings held
at Parliament Buildings,
Toronto, Ontario, on Thursday,
the 29th day of September,
at 11.00 a.m.

COMMITTEE:

MR. H. L. ROWNTREE, Q.C. - Chairman

MR. A. WREN

MR. J. A. FULLERTON

MR. J. TROTTER

MR. R. E. SUTTON

MR. R. J. BOYER

MR. N. WHITNEY

MR. H. J. PRICE

MR. K. BRYDEN

MR. J. WHITE

MR. G. F. LAVERGNE

MR. S.J. GADSBY, F.C.I.S. - Secretary



Thursday,
September 29, 1960.

---On resuming at 11.00 a.m.

THE CHAIRMAN: Gentlemen, are we ready to commence? This is the resumption of the Select Committee on the Cost of Drugs and at this point I would like to introduce Mr. Harold Rice who has been retained by the Committee as its counsel and will be taking part in the proceedings, to everyone's benefit I hope.

Now during the recess, a questionnaire was prepared and was distributed to the various hospitals, which might generally be described as the non-Government hospitals throughout the Province. The Secretary will -- I have a copy of this questionnaire and I think that it should be filed as an exhibit. What exhibit is that?

THE SECRETARY: No. 9.

--- EXHIBIT NO. 9: Questionnaire.

THE CHAIRMAN: Now before proceeding with the evidence, I would like to speak to the question of sittings. Now today we cannot sit any later than three o'clock because the space is required on a previous arrangement. We will be sitting tomorrow morning and certainly next week, and then we jump to the 19th of October and at that point we will be sitting fairly steadily and I make these observations because I think that the period of time since the



1 Committee was appointed, and the other period of
2 time since we adjourned has provided an ample
3 opportunity for all interested parties to prepare
4 their material and to be able to proceed with their
5 cases, we might call it.

6 I am concerned with respect to the Ontario
7 Dental Association. They are involved at the moment
8 in a convention with the Canadian Association, and
9 I am going to instruct the Secretary on Monday,
10 after this convention is over, to get hold of the
11 Chairman of the Ontario Dental Association, secure
12 from him a list of the names and addresses of all
13 of the officers of the Ontario Association, and the
14 names and addresses of the officials of the
15 Canadian Association.

16 The many fields that the purview of this
17 Committee extends to the use of drugs by dentists,
18 whether or not they think so, and if you will get
19 that information, Mr. Secretary, then we will proceed
20 on that score.

21 Now at our hearing in June, I indicated
22 at the outset to the manufacturers that there were
23 some matters that should be included in a factual
24 way in any presentation. Now, is there anyone from
25 the Canadian Manufacturers -- Pharmaceutical
26 Manufacturers Association present?

27 MR. MARTIN: Mr. Chairman, I am appearing
28 on behalf of Mr. Hume.

29 THE CHAIRMAN: You are Mr. --- ?
30



1 MR. MARTIN: Mr. Martin, and I am here,
2 sir, out of courtesy to your Committee and to request
3 that we be allowed to file our brief on or before
4 the 19th of October and that we would be prepared to
5 proceed in any case, on that date.

6 THE CHAIRMAN: I think that the way the
7 schedule looks, Mr. Martin, that nature will take
8 care of itself because I think we will have ample
9 material and witnesses to deal with between now and
10 the 19th, and there will be representatives from
11 the Connaught Laboratories and some other witness
12 in connection with the operation and the nature of
13 the Food and Drug Act, and so I see no problem there.

14 However, Mr. Martin, I would like to say
15 to you that in the meantime, firstly, I don't think
16 your brief, -- as I understand it, it is a major
17 presentation?

18 MR. MARTIN: It is, sir.

19 THE CHAIRMAN: It would be hopeful to us
20 if it might be distributed, or filed with us sometime
21 in advance so that we might at least study it.

22 MR. MARTIN: The situation, sir, is that
23 some economic experts have been engaged by the
24 Association. Their report, which is expected
25 momentarily, has not as yet been received.
26 It is a separate phase of the brief.

27 Also, the Association has gone to a great
28 deal of trouble circularizing their members,
29 unfortunately, throughout the summer when there was
30



1 some difficulty in obtaining answers. This material
2 is now prepared and is being edited and we hope to
3 have this filed in a very, very short time.

4 THE CHAIRMAN: Mr. Martin, is Mr.
5 Conder with you?

6 MR. MARTIN: He is, sir.

7 THE CHAIRMAN: Are there any other manu-
8 facturers of drugs who are non-members of this
9 Association present, or represented?

10 --- (No reply.)

11 THE CHAIRMAN: Well, gentlemen, what I
12 would like to say to you is this: that there is a
13 statement of facts, certainly not any controversy,
14 but I referred to it last June, and to my knowledge
15 we have not received it and I ask for a list of the
16 manufacturers of drugs be made out, showing their
17 place of business, their head office, whether or
18 not they carry on research operations, whether they
19 are manufacturers or are they distributors, and
20 information of such a nature.

21 Now, I think we can go ahead with that,
22 and that is something that won't hold up your
23 other brief, but I think we would like to have that
24 as quickly as possible. Could that be done?

25 MR. CONDER: Yes, it could, Mr. Chairman.
26 We have supplied the Committee with a list of all
27 the companies, and a breakdown to date that we have
28 been able to ascertain. It is extremely difficult
29
30



1 in knowing what some companies do which are not
2 members of our Association. We would be only too
3 glad to co-operate with the Secretary of the
4 Committee in any way possible with this respect.
5

6 THE CHAIRMAN: If you cannot get the
7 information, just note it opposite the name and
8 we will get it.

9 Now the next thing, there are a couple
10 of other items generally. I think it would be of
11 interest -- there should be a notation as to whether
12 these companies are Canadian companies. I am not
13 talking about jurisdiction. Are they Canadian
14 companies as against foreign companies? Do we know
15 if they are Canadian-owned?

16 MR. CONDER: It would be possible for us
17 to do that with the information at our disposal.

18 THE CHAIRMAN: That would be helpful.
19 Thank you. There is no one present who is a non-
20 member or representing a non-member of the Pharma-
21 ceutical Manufacturers Association? Because the
22 remarks that I have made with respect to the
23 Association members would apply to them as well.

24 Now we will proceed with the evidence from
25 the Department of Public Welfare. Is Dr. Stuart
26 present? Mr. Ludlow, are you going to lead off?

27 DR. STUART: Mr. Ludlow will be.

28 THE CHAIRMAN: Mr. Ludlow, you are Mr.
29 L. E. Ludlow, Director of the Home for the Aged
30 Branch of the Department of Public Welfare?



1
2 MR. LUDLOW: Yes, Mr. Chairman. Mr. Chairman,
3 Members of the Committee, my Deputy has asked Dr.
4 Stuart, who is the senior medical specialist for our
5 Branch, and myself to appear.

6 We have no written brief, but as you know,
7 drugs are becoming more and more important in our
8 Homes for the Aged throughout this Province.

9 If I may, Mr. Chairman, I would like to give
10 a brief synopsis of what our Homes for the Aged are.
11 There are two Acts under which Homes for the Aged
12 operate here in this province. One is the Homes for
13 the Aged Act, 1956. The other is the Charitable
14 Institution Act.

15 The first are homes for the aged owned and
16 operated by municipalities.

17 The second are homes for the aged owned and
18 operated by charitable institutions, private
19 organizations, church groups and so on. Now then,
20 previously to 1947, the Municipal Homes were operated
21 under the House and District House Homes, the
22 District House of Refuge Act. In 1947, there was
23 a change in that and the Provincial Government at
24 that time made its first recognition of these homes
25 in the way of contribution of 25 per cent of the
26 cost of construction. Previous to that, the amount
27 of any grant by the Government was \$4,000 for the
28 entire institution.
29
30



1 In 1959 a new Act entirely came into being.
2 This Act is known as the Homes for the Aged Act, and
3 the Government at that time contributed 50 per cent
4 of the cost of new construction of new Homes or
5 additions or extensions to Homes, and 50 per cent
6 of the cost of maintenance, operation and maintenance,
7 which meant that we were then - or the Government
8 was - contributing to the cost of medical care of
9 the residents of the Homes.

10 The Act at that time noted in Section 13
11 of the Act the types of persons who may be admitted
12 to the Home, and they were broken down into three
13 classes: first - and I am giving this from memory
14 so that the exact wording may not be correct - any
15 person who is over the age of 60 years and cannot
16 look after themselves who need care.

17 Class B, anyone who is not admissible to
18 an Ontario Hospital who needs care and protection.

19 Class C, anyone over the age of 60 years
20 who is confined to bed, but does not need care in
21 a General Hospital or a Hospital for incurables.

22 D, anyone under the age of 60 years who
23 cannot be cared for adequately elsewhere, when approval
24 has been granted by the Minister.

25 These were the types of persons, or are
26 the types of persons who are admissible to our
27 municipally-operated Homes for the Aged. Now then,
28 under class C, persons who are confined to bed, this
29 type of care has been increasing day by day. In fact,
30 there are not sufficient beds at the present time in



1 our Homes to care for this need. That is demonstrated
2 quite clearly here in Metropolitan Toronto, who cannot
3 or have not up to date been able to have sufficient
4 accommodation for this type of care. I may add, they
5 are doing a tremendous job and have increased their
6 bed capacity.

7 Along with this, has been coming the added
8 cost of drugs and medications. This has been
9 increasing greatly, and I would like to come back and
10 state this: that in 1947 there were 34 municipally-
11 operated Homes for the Aged, and there was no
12 accommodation for bed care. They were the congregate
13 type of care homes.

14 In 1947 there were 40 charitable institutions
15 and no bed care. In December 1956, 22 of the 46
16 municipally operated Homes for the Aged had accommodation
17 and was caring for bed-care residents.

18 If I might interject in there, Mr. Chairman,
19 for those who are not familiar with the type of
20 care given in our Homes for the Aged, I would say
21 that it has been a boon to municipalities. It has
22 been a great help in finding accommodation for those
23 who are not eligible for hospital insurance. The
24 type of care is for those that are confined or
25 semi-confined to bed, but do not need sustained medical
26 care, who are ineligible for hospital insurance
27 either in a general or chronic hospital. I am
28 giving this little information there so that you
29 can understand these people are not eligible for
30 care in a hospital or chronic hospital.



1 In 1959 the Homes with bed care had increased
2 to 33 out of 51. In June 1960, 34 of 52 municipally-
3 operated Homes for the Aged are caring for this
4 type of person.

5 In December 1956 there were 54 charitable
6 institutions. In 1959 there were 58 charitable insti-
7 tutions. In June, 1960, there are still 58 charitable
8 institutions, but only four of those Homes have
9 sections for bed care.

10 In December 1956, there were 5,102 residents
11 in our municipally-operated Homes for the Aged. In
12 December 1959, there were 6,445 residents, an increase
13 of 1,514 or 25.65 per cent.

14 In bed care in 1956 there were 1,155. In
15 1959 there were 2,088, an increase of 933 or approx-
16 imately a 80 per cent increase in bed care. At
17 the end of June of this year, there were 2,234 in bed
18 care in municipal homes, an increase of 1,079 from
19 December 1956, or an increase of 93 per cent.

20 In December 1956, bed care - what we
21 term special care: those are the confused or senile
22 persons who are ineligible for admission to an
23 Ontario Hospital, who also need considerable care
24 and medications at times - they composed 47.4 per
25 cent of the residents in our municipally-operated
26 homes. In 1959 that had increased to 57 per cent
27 of the care.

28 In June 1960, these two types of care
29 amounted to 58.1 per cent. Gentlemen, that is quite
30 an increase, and demonstrates, I feel, that our



1 municipalities and governments are feeling they are
2 their brothers' keeper in helping to maintain these
3 types of persons.

4 Now then, possibly you are not familiar
5 with the grants that the Provincial government make
6 to these two types of homes. The municipally-
7 operated homes, the government gives a grant of 70
8 per cent of the net cost of operating these homes.
9 The Federal Government does assist the Provincial
10 Government in some of this, but not in the cost of
11 drugs or in medical care or some other items.

12 Charitable institutions, the government
13 makes a grant or subsidy payments of 75 per cent
14 of the cost of the home up to a ceiling of \$3.40
15 per day. I might add that residents in both types
16 of homes are asked to pay on their ability to pay
17 to the cost of maintenance. These are not homes
18 for indigents alone.

19 Now then in 1956 drugs and medications
20 in our municipally-operated homes, the amount of .
21 \$76,988.68 was expended. In 1957 the amount was
22 \$113,174.21. In 1958, \$167,141.24. In 1959, \$192,319.34.
23 Add to that in 1958, \$36,701.86, which was the
24 cost or the amount expended in charitable institutions
25 for drugs, making a total for the year 1958 of
26 \$203,843.10.

27 In 1959 the amount by charitable institutions
28 was \$42,503.37, or a total for 1959 expended on
29 drugs of \$235,022.71. That is quite a considerable
30 amount of money.



1 Now then, Dr. Stuart and myself have discussed
2 these costs, and have tried to form our own ways
3 and means committee to see what could be done, some
4 way of lowering the cost, whether it would be bulk
5 buying or what it might be by the homes. We have
6 discussed these things, and are hopeful that some
7 solution may be made. Possibly you gentlemen might
8 help us in that.

9 Now then with life expectancy increasing
10 and the increasing number of elderly people in homes
11 for the aged and needing nursing care, no doubt our
12 costs of drugs and medications will increase. I
13 would suspect that the average age of applicants today
14 for our homes for the aged is approximately 73 years
15 of age.

16 Now then, just the beginning of this month
17 we sent out a questionnaire to the municipally-
18 operated homes for the aged, asking the number of
19 residents in the home, and their ages. I think it
20 may be of interest to this Committee to know the
21 ages of the people that are being cared for in our
22 homes for the aged, and would more readily understand
23 the need of drugs and medications which has been
24 helpful in maintaining a much longer life span.

25 52 homes were sent this questionnaire,
26 Up to today we have heard from 42. 60 years and
27 under, there are 370. 60 to 69, 784. 70 to 79,
28 2,195. 80 to 89, 2,340. 90 to 100, 454. Over one
29 hundred, 7.

30 Gentlemen, this shows that we are living



1 longer, and that we are getting good care medically
2 and humanly, and I would like to break this down.
3 If you will look at these figures, you will find that
4 of the ages between 70 and 79 there are 35.691
5 per cent. 80 to 89, 38.049 per cent. You can see
6 that even in this age of 80 to 89 the type and
7 number of persons that are being maintained in our
8 homes needs a great deal of medical care.

Page 295 follows.



1 Medical care, then, means drugs in a great
2 many cases. So I think that even when you see that
3 90 to 100, that is 7.383% of the population.

4 Sir, my deputy has asked me to thank you
5 for your indulgence and hope that it may be of some
6 benefit to you in your deliberations. If you like,
7 Dr. Stuart who is with me can go into any of the more
8 technical phases.

9 THE CHAIRMAN: Thank you, Mr. Ludlow. Before
10 you step down, might it be said accurately that while
11 your department and the government supports the
12 municipalities with respect to these homes, that the
13 actual administration is by the municipalities.

14 MR. LUDLOW: Homes are owned and operated
15 by the municipalities. Naturally that will have to be
16 consistent with the act and its regulations. We do
17 inspect, advise in a great many ways in the operation,
18 instruction and so on. We have our specialists in that
19 work.

20 THE CHAIRMAN: Could you tell us about the
21 mechanics of medical treatment with respect to the
22 citizens of these homes.

23 MR. LUDLOW: I think possibly Dr. Stuart
24 might give you the technical end of that better, but
25 each home has a physician. The home has to have a
26 physician appointed and on his shoulders rests a great
27 deal of that, but that does not say, sir, that all
28 residents of that home have to think that he is their
29 doctor. Thank God we still live in a democracy and
30 that we can have the solicitor or doctor or whatever



1 it is of our choice.

2 MR WREN: Mr. Ludlow, Mr. Chairman, through
3 you you mentioned a category of sixty and under of which
4 there are 370 in the homes reporting. What would be
5 the youngest age you know of.

6 MR. LUDLOW: Under sixty?

7 MR WREN: Under sixty.

8 MR. LUDLOW: The type of person there, may
9 I say, Mr. Chairman, and Mr. Wren, are the persons who
10 are mentally confused - not mentally confused, but
11 need some type of care.

12 Now that might be some person that may be
13 50 years of age, may be 45 years of age, that the
14 mother and father has cared for in the home who has
15 been physically handicapped. One of the parents may
16 have died and the other one unable to care for this
17 person and there is no other place for them, no one
18 that will look after them, so that they apply for
19 admission to the home. That is done with the approval
20 of the Minister because it is quite necessary, that
21 they must have things examined that they want a person
22 in a home of that kind.

23 MR WREN: It could be any adult. It could
24 be anyone over 21.

25 MR. LUDLOW: It could be. In fact, that
26 is one of the things, that when a younger person's
27 application comes in, his application is reviewed to
28 see what can be done, and if it is in the best interests
29 of the applicant to have him admitted there, because
30 we don't want that home to be used as a dumping ground



1 for the unwanted person in the community, and so it
2 is with the approval of the Minister.

3 MR. BOYER: Would most of these people be
4 receiving a disability pension?

5 MR. LUDLOW: Some may and some are not. In
6 the case of the disability pension if they cannot pay
7 50 percent of the maintainence, the disability pension
8 ceases.

9 MR. BOYER: But the disability pension would
10 not be turned over to the home?

11 MR. LUDLOW: The disabled person's allowance,
12 I presume you are referring to.

13 MR. BOYER: Yes.

14 MR. LUDLOW: No.

15 MR. WREN: Where does the disabled person go
16 that is not in the home for drugs?

17 MR. LUDLOW: That I cannot answer, sir. I
18 think possibly they might have this medical card, yes,
19 the medical card is supplied to them.

20 MR. WHITE: Mr. Chairman, the drug costs
21 by years that Mr. Ludlow gave, is that the total cost
22 or the provincial share?

23 MR. LUDLOW: The total costs.

24 MR. WHITE: And the province pays 7%.

25 THE CHAIRMAN: Thank you, Mr. Ludlow.

26 -----
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1 --- Dr. Keith Stuart came forward.

2 THE CHAIRMAN: This is Dr. Keith Stuart who
3 bears the office of Special Geriatrics Consultant.
4 What does Geriatrics mean Dr. Stuart?

5 DR. STUART: Mr. Chairman, the definition of
6 "Geriatrics" comes from the Greek, the word "Geran"
7 an old man, and "Iatrics" meaning treatment of; so
8 that the word has a medical connotation. There are
9 other terms such as: "Gerontology" and so forth, which
10 is more of the study of the social aspects, whereas
11 "Geriatrics", its connotation is primarily in relation-
12 ship to the medical or treatment aspects.

13 Gentlemen, I have one further word to give
14 you some idea of our interest in this general picture
15 of drugs. Going around the province, I have asked
16 the superintendents of these homes that have been there
17 for three years or longer, if they notice any difference
18 in the application, and universally, they have said,
19 "Yes, there are two things. One, they are older, and
20 two, they are more infirm either mentally or physically."

21 So that, as a general statement that applies,
22 you could say, if there were 10% of the total of those
23 folks that were not on some form of medication more or
24 less continuously - that would be an educated guess -
25 so that in a matter of 12 years from a place that
26 housed primarily well persons that could be actually
27 contributing to the upkeep and maintenance of the in-
28 stitution, we have come to a place where, through the
29 good offices of section 13 of the Homes For The Aged,
30 people requiring care are those that are coming into



1 these homes.

2 So, the 93% increase in population in three
3 and one half years, and the number with bed care - I
4 think one other word of orientation may be given. That
5 is, as far as these persons or as far as our medical
6 program is concerned, we have no interest in becoming
7 a hospital, and we are very much interested in trying
8 to make these into homes so that we feel we are supplying
9 a maintenance type of medical care for reasonably
10 stabilized illnesses that do not require too much
11 by way of laboratory assistance or skilled observation.

12 One might say that the homes are resident
13 oriented, whereas, hospitals and chronic hospitals,
14 which is your closest differentiation are disease
15 oriented.

16 That doesn't mean that a medical condition
17 precludes a person entering, far from it, but it does
18 mean that medical problems are precluded. A diabetic
19 on a reasonable diet - and special diets must be pre-
20 sented in these homes - gets his insulin or his oral
21 anti-diabetic substance, and is maintained as long as
22 he is not an acute medical problem.

23 Certainly, our facilities are primarily for
24 taking care of people and not disease, and if he becomes
25 a problem, he has to be moved into a hospital.

26 I think that little bit of background and
27 the figures that Mr. Ludlow has given you about the
28 actual costs involved will show you that drug costs
29 have been a problem that has caused considerable
30 cogitation in our department, and we have tried to



1 examine ways and means, because some of these homes
2 are in areas widely scattered throughout this province,
3 and the access of information is maybe not as free as
4 it is in some of the more highly developed urban centres,
5 of providing good medical care and good drug therapy
6 at the most reasonable cost.

7 In some of our explorations - and as Mr.
8 Ludlow suggested, we would look to this committee for
9 help - we have explored the possibility of making,
10 through a committee of superintendents of these homes,
11 mass purchases. In doing so, and in preliminary in-
12 vestigations with the drug manufacturers, they have
13 been receptive to this approach, provided that the
14 deliveries were specified within a certain period, and
15 that they were in certain bulk quantities.

16 This is fine, and it sounds quite easy, but
17 there is a multitude of new drugs coming on the market.
18 That comes close to this particular idea in one way,
19 and in one way approaches it from another angle and
20 as far as we are specifically concerned the complete
21 pharmacology or the complete action of drugs as applied
22 to elderly persons has not been fully explored, and
23 that is one of the deficiencies of my own profession
24 and of the pharmacologist too.

25 The reason for this, and I think everyone is
26 aware of this, is that the bulk purchases can at times
27 provide a rather marked decrease in price. However
28 this problem of bulk purchases - unless you can buy,
29 I don't know what you would call it-in a real business
30 sense you would probably call it a consignment type of



1 thing - whether you take acetylsalicylic acid, or aspirin
2 and say,

3 "We are going to use one million tablets in these
4 homes, let us tender for the price for the year
5 1962 on the basis of one million acetylsalicylic
6 acid tablets to be delivered in lots of less than
7 five thousand to the home."

8 If this were done, the home could simply
9 make an application to that particular manufacturer for
10 this particular product, and they would ship them to
11 the home.

12 That has been accepted. I have spoken to
13 some men in the drug industry and that seems to be a
14 reasonable procedure to them, to facilitate certain
15 things in their deliveries, and it certainly does to
16 us.

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18 (Page 306 follows)
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1 DR. STUART: However, I think that when
2 one thinks of those things you have to consider
3 first, and find out the drugs in common usage in the
4 institutions concerned, and that requires considerable
5 investigation and some degree of latitude for personal
6 preference.

7
8 However, when these things are established
9 as a base line, then the purchase is relatively
10 simple but in order to perpetuate and keep up with
11 the times, if one undertakes such an approach then
12 there has to be within that organization, or within
13 the group covered by the mass purchase some continuing,
14 some method of a continuing assay or evaluation of
15 the value of these newer drugs to the specific situation
16 under consideration.

17 In other words, this drug comes out and it
18 will be thus and do so, and they have spent a lot of
19 time, a lot of effort investigating it and they say
20 that it has certain properties. Well now, whether
21 those properties apply -- I am speaking personally --
22 whether they apply to our particular programme
23 requires, I think, some planning on our part to make a
24 continuing assessment of its application to our
25 particular needs. That would be one consideration that
26 I would foresee in that sort of thing; the mass
27 purchase -- when you are all concerned about quality,
28 and there is certainly no point in spending one's
29 own personal money, or certainly not that of the
30 people at large, the money with which you are



1 entrusted, there is certainly no point whatsoever in
2 spending that for drugs that are not potent and that
3 some form of control certainly is involved in the
4 procedure.

5 Certainly leading drug houses in perpetuating
6 their business, certainly interject very fine controls
7 and so even if your bulk purchase was in that field,
8 one might just leave it as such and take their word
9 for it. Or there might be some central -- reports
10 available from some central agency that might assess
11 them or there might be some combination of them.

12 Then there is another item that certainly
13 is involved in this as far as we are concerned, and
14 that is that one might well have a preference for a
15 particular brand which in essence is the same thing
16 generically and that we do not feel that we are too
17 wise to support. In fact, we are thinking in terms
18 of generic names but when you think of generic names,
19 or purchases under generic names, then one must be
20 assured of the quality of the drugs.

21 Those are some of the problems that we
22 have been wrestling with in the Homes for the Aged
23 Branch of the Department of Public Welfare and they
24 are some of the things with that bit of orientation
25 that we are hoping that the deliberations of this
26 Committee might help us out with. I think that is all
27 I have to say specifically, Mr. Chairman.

28 THE CHAIRMAN: Dr. Stuart, would you have
29 any idea of what the total drug bill would be with
30



1 respect to the Homes for the Aged in this Province?

2 DR. STUART: The total drug bill?

3 THE CHAIRMAN: Yes.

4 DR. STUART: No, I wouldn't, Mr. Chairman.
5 Certainly the figures mentioned by Mr. Ludlow in 1959
6 around 235,000 is the actual money expended by the
7 organizations themselves. Particularly in the
8 charitable institutions, there are many persons who
9 actually go out. They are a more ambulant type of
10 population and they go out and see their own physician
11 and make their own private purchase themselves in
12 many, many instances.

13 THE CHAIRMAN: I will tell you why I am
14 asking this question: while it's a substantial amount
15 of money, it is not a large amount in the total
16 picture. However, it is still a large amount of money
17 but more important that that it happens to deal with
18 the segment of our population which is a segment
19 which must be taken into very serious account, that
20 is the older people and the indigent group, and that
21 segment, I think, merits some very careful attention
22 in the broad picture of things.

23 Would it be possible to find out from your
24 experience what the relationship would be between
25 the drugs used by, or prescribed by the house doctor
26 Mr. Ludlow referred to, and the let us say, the
27 personal family physician and to go on, similarly,
28 the same information about what stock or inventory
29 might be carried.
30



1
2 DR. STUART: In answer to the first question
3 in the municipally operated Homes for the Aged, the
4 figures mentioned -- this is only a guess, but I
5 would hazard that that covers close to 90 per cent of
6 the drug cost in those institutions. These men are in
7 attendance more or less regularly, and it becomes
8 increasingly common when someone is ill for them to say
9 well your doctor is coming in today, is he? Yes.
10 Well I would like to see him, and so it becomes
11 increasingly common for him to take care of an
12 increasing number of the residents in the Municipal
13 Home.

14 Where the visitation is not so regular,
15 then of course there is a wide fluctuation and so
16 in the approximately 30 -- around \$40,000 that was
17 noted in the charitable institutions I would imagine
18 represented only a small portion of that, the drug.

19 There are no breakdown figures to tell at
20 the moment what is prescribed by the house physician,
21 as you call him, or the physician of the Home as
22 opposed to the visiting physician.

23 THE CHAIRMAN: Would the Welfare Department
24 of the various municipalities have these costs
25 broken down?

26 DR. STUART: No. At least, I very much doubt
27 if they would. Those costs would be in our Department;
28 come in through Inspectors' Reports.

29 THE CHAIRMAN: Would they be available to us
30 then?



1 DR. STUART: Yes, they would be available.
2 Not the breakdown, sir.

3 THE CHAIRMAN: Not the breakdown?

4 DR. STUART: No sir. That has never been
5 broken down. I am sure you would find the 10 per cent
6 that might fall into, that is a high figure.

7 MR. WREN: Mr. Chairman, may I ask Dr. Stuart
8 where someone doesn't use the services of the house
9 physician, where he is free to choose his own doctor
10 and that doctor prescribes certain drugs for his
11 treatment, who pays the bill in that case and how is
12 it paid?

13 DR. STUART: The bill is paid on the
14 approval of the house physician and the superintendent.
15 If that material is available in the dispensary it is
16 drawn from there.

17 MR. WREN: Does the house physician adjudicate
18 the necessity of that drug?

19 DR. STUART: That is not completely forma-
20 lized but it is common practice.

21 MR. WREN: The house physician determines --
22 I am thinking in terms of where it might be a very
23 expensive drug.

24 DR. STUART: Yes, that particularly and
25 occasionally some of those get back to us.

26 MR. WREN: If the dispensary doesn't have
27 it, it would go on to the local retail drug store?

28 DR. STUART: Depending on the quantity or
29 the expected duration of treatment.
30



1 MR. FULLERTON: With the mass buying of
2 drugs, is there deterioration on these drugs?

3 DR. STUART: There is in certain particular
4 drugs in that they would have to be limited in their
5 delivery. Others are quite stable.

6 MR. FULLERTON: I didn't get it clear.
7 You mentioned consignment.

8 DR. STUART: Well I mean -- that was just
9 simply a lack of term on the part of the English.
10 The fact that this company would contract for the
11 one million acetylsalicylic acid tablets and simply
12 requisitions them or orders them directly from that
13 person and those bills would be paid still in the
14 same order but it would give them an opportunity to
15 channel their production at the time at which they
16 get the tender.

17 MR. FULLERTON: What becomes of the drug
18 when more effective drugs come into being? Would
19 they be returned to the ---

20 DR. STUART: No, I wouldn't imagine so.
21 Actually, the introduction of these drugs and their
22 availability is a gradual thing and even when you
23 decide that this one is 20 per cent more effective
24 than the one that has been used, and has been your
25 base line, you find people that have done perfectly
26 well on this other drug and you would hesitate to
27 remove them from that and go through and create
28 another problem in rebalancing so that any excess
29 you had left over, as long as your inventory had been
30

1 reasonable, would be taken up or taken care of by
 2 those that were already doing well on it, and you
 3 would certainly take them through on that and then
 4 you would go on and start introducing your improved
 5 medication.

6 MR. BRYDEN: Mr. Chairman, I would like to
 7 ask two questions of Dr. Stuart. First of all, with
 8 regard to the mass purchasing for homes for the aged
 9 has any consideration been given to the possibility
 10 of consolidating the efforts of your department with
 11 the efforts of the Health Department which I believe
 12 already has a programme, to some degree, of purchasing
 13 for its own institutions?

14 DR. STUART: Mr. Chairman, that has not
 15 proceeded to that particular level. As was brought
 16 out by the Chairman in one question he asked Mr.
 17 Ludlow, there is some difference between the two
 18 situations, and the first thing is that the Department
 19 of Health, theirs is a direct responsibility; ours
 20 is an indirect responsibility through the local
 21 autonomy of the Board that operates the Homes and so
 22 that the approach to that is a little different.

23 MR. BRYDEN: I can appreciate that.

24 DR. STUART: Oh well, I mean it's quite
 25 foreseeable but it hasn't gone to the stage where
 26 there have been -- that had been considered as a
 27 fait accompli of any sort and therefore we had not
 28 gone or made any representations for inclusion.

29 MR. BRYDEN: One other thing that came to
 30



1 mind, Dr. Stuart, when you were presenting your
2 submission with regard to the problem of testing
3 drugs, particularly those being supplied in the
4 generic names, their efficacy and reliability, I
5 believe that the Department of Health has now just
6 embarked on a programme of having the AG's Lab. do
7 testing for them. Would you visualize that that might
8 be a possibility in your case to ask the AG's Lab to
9 extend these facilities?

10
11 DR. STUART: I will speak personally on this,
12 if I might. As far as I am concerned before I would
13 recommend any given drug to any person, and particularly
14 is that true before I recommend its use by any
15 individual who had in any manner lost, or felt they
16 had lost any degree of the ability to make up their
17 own mind -- the people in institutions often feel
18 they must take what is provided, and therefore, before
19 I personally would have any part of recommending that
20 they take anything that I was not assured of, I would
21 not participate.

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1 If this were the source of assurance, then that would
2 be the source I would use.

3 MR. BRYDEN: As I understand the program
4 the A.G. lab is attempting to undertake, it is merely
5 a matter of testing the products supplied to determine
6 whether or not it has in it what it is purported
7 to have?

8 DR. STUART: Yes.

9 MR. BRYDEN: It does not I think infringe
10 at all on the prescribing --

11 DR. STUART: No, but I am talking personally.
12 I would not use this drug bought by the generic
13 name unless I knew the company and its general policies,
14 or I had from an independant central source an
15 opinion assuring me that it contained what it was
16 supposed to contain and in the proportions laid down
17 on their labels. So that would be, if that was
18 the source, and bought by generic name, some research
19 would be an essential before I could personally
20 feel free to advocate its use under any circumstances.
21 I think we are speaking of the same thing.

22 MR. BRYDEN: I think so, yes.

23 MR. WHITE: Am I correct in thinking that
24 each home for the aged buys its own drugs?

25 DR. STUART: You are quite correct.

26 MR. WHITE: Would it have any opportunity
27 that the costs be scrutinized?

28 DR. STUART: Monthly.

29 MR. WHITE: Do you know if some of the Homes
30 for the Aged are paying more for certain drugs than



1 other homes?

2 DR. STUART: No, that is not at present. This
3 whole program is receiving more attention recently.
4 In the last couple of years. We keep a per diem rate
5 on drugs, and if those get out of line at all, we
6 then requisition all their invoices, and from that
7 we find out whether or not they have been paying an
8 excessive price for this one, or buying this in an
9 excessive quantity over and above reasonable utilization,
10 and then go out - have inspectors go out or I go
11 out - and talk it over and see what we can do about
12 straightening it out. It is an indirect thing,
13 but there are moves afoot which may make me answer
14 that more precisely in a few months' time.

15 THE CHAIRMAN: You referred to deterioration.
16 What drugs would come to mind as being subject to
17 rapid deterioration?

18 DR. STUART: Well, one that is more or less
19 an old classic is tincture of digitalis; that comes
20 down very rapidly. However, that is not merely
21 as much used today, although we still have it used
22 in some of our homes. The tablet is relatively
23 stable.

24 Certainly most of these drugs can be bought
25 on a three-month basis. Basis of three months' supply.
26 I can think of none that if kept under the directions
27 sent with them that would not be good for at least some
28 time.

29 THE CHAIRMAN: Is it fair to say three
30 months might be a reasonable period of stopping the



1 drugs generally, or am I being too broad and sweeping?

2 DR. STUART: I think that is maybe a
3 little broad. It is according to my conception.
4 The policy that has been advocated to these various
5 homes is that they keep a running inventory and they
6 know approximately, we will say, from weekly utilization
7 of any given drug that is in there, and they allow
8 this inventory to go down to a certain minimum
9 which is sure to cover them until the next order
10 goes in to their source of purchase, and is returned.

11 That might vary depending on the amounts
12 used and the availability of a particular drug.
13 That has been the policy in general.

14 THE CHAIRMAN: Having in mind the nature
15 of your position and the department's position with
16 respect to the municipalities, and their individual
17 operation of these homes, I regard you as somewhat
18 independant from them. Have you any knowledge of
19 any clinical testing on the subject with respect
20 to drugs and the subject of geriatrics in the homes
21 for the aged which we are talking about?

22 DR. STUART: Yes, I do. The Department
23 of Welfare in association with Metropolitan Toronto
24 has opened an operated just such a centre, which is
25 being operated in the confines of Metropolitan
26 Toronto. It is actually housed in Lambert Lodge.
27 It serves the 1,850 people in the four homes for the
28 aged in Metropolitan Toronto. It is staffed by
29 a staff of well-recognized eminent consultants in
30 the various branches of medicine, and they see problems



1 from these homes. As they see the problems - this
2 has only been going on since, well, since the spring -
3 as they see problems they are developing programs.

4 THE CHAIRMAN: Are these programs in connec-
5 tion with the hospitals?

6 DR. STUART: No.

7 THE CHAIRMAN: Or with drug companies, or
8 what research bureau is sponsering it?

9 DR. STUART: This is the Geriatric Study
10 Centre, and it is the sponsering agent.

11 THE CHAIRMAN: Geriatric Study Centre of
12 what?

13 DR. STUART: Of the Department of Public
14 Welfare.

15 THE CHAIRMAN: Of your own department?

16 DR. STUART: Of our own department, yes.

17 THE CHAIRMAN: I see.

18 DR. STUART: It operates through a Minister's
19 advisory committee made up of five medical men and
20 one layman.

21 THE CHAIRMAN: Do drug manufacturers partici-
22 pate in this study?

23 DR. STUART: Yes, they do, on ones that
24 look to be applicable to our situation, and then
25 they provide us with all their known knowledge of
26 it, and if it meets with the approval of the Minister's
27 advisory committee, then a program and its controls
28 are established, and the information from that, by
29 agreement, must be made available to all the physicians,
30 to the homes for the aged throughout Ontario, and any



1 other interested person, so that if it works well,
2 they must know about it; if it does not work well,
3 they must know about that too as far as we are
4 personally concerned.

5 MR. WREN: Might I ask, Dr. Stuart, of
6 the total number who are inmates of municipally-
7 operated homes for the aged, roughly what percentage
8 are in Metropolitan Toronto and what percentage are
9 elsewhere?

10 DR. STUART: I am not sure in actual
11 percentages, but give or take a few, it will be
12 somewhere around 28 per cent. I am not sure if it
13 is 20 or 30 per cent. Six thousand, four hundred
14 and some odd, and there is around 1,840 in the
15 Metropolitan Homes.

16 MR. WREN: So you have a good field of
17 research?

18 DR. STUART: We have a good field, and
19 therefore, the numbers and conditions are varied
20 enough that their application could quite readily
21 be made to any home throughout the province.

22 THE CHAIRMAN: I think it was Mr. Ludlow
23 who made reference to a medical card which was issued,
24 and I meant to ask him what he meant by this card.
25 Do you know anything about that?

26 DR. STUART: Yes. The medical card - I
27 cannot tell you the entire group to whom it is avail-
28 able; persons for instance on old age assistance
29 who have passed the means test, and I believe children
30 in the care of the Children's Aid, those receiving



1 disabled persons' allowance. Now, I may have forgotten
2 others, but that general group are supplied with
3 a medical card which entitles them to service in
4 their home or in the doctor's office from the physician
5 of their choice, and that is operated through agreement
6 with the Ontario Medical Association, the Ontario
7 Medical Association Welfare Fund, to which our
8 department makes a per capita contribution. That is
9 the source of their medical care in their homes or
10 in the doctor's office; not in hospital.

11 THE CHAIRMAN: Up to now we have been talking
12 about the homes for the aged. What about your
13 department's position with respect to welfare, as
14 such, and again as I understand it, welfare departments
15 are operated by municipalities but there is support
16 from the province. Could you address yourself to
17 that?

18 DR. STUART: I have not addressed myself
19 to that particularly. My knowledge of that is some-
20 what diluted. It is a large problem, but it is a
21 rather difficult one to define. The little I do know
22 about it, the intimate control of it occurs through
23 municipal agencies, and has advantages that one
24 is better not to disturb at the present moment.

25 THE CHAIRMAN: I think it is desirable
26 that we have something on the record having to do
27 with the mechanics of what happens to an indigent
28 who comes out of hospital and the hospital services
29 scheme does not apply, but he requires continued
30 treatment, including the purchase of drugs.



1 DR. STUART: Yes.

2 THE CHAIRMAN: But he is on an out-patient
3 basis, and therefore comes in under the Department
4 of Welfare. Would you have any knowledge of those
5 mechanics?

6 DR. STUART: Intimate mechanics of that
7 I do not know.

8 THE CHAIRMAN: Do you, Mr. Ludlow?

9 MR. LUDLOW: Before I answer that, Mr.
10 Chairman, while I have it in mind, may I add a little
11 to the question asked of Dr. Stuart by Mr. Wren
12 about a reference to those persons who have their
13 own doctor and the doctor prescribes. A great
14 many of those residents pay for their own prescriptions.
15 If they have the money, they pay for their own
16 presecrption.

17 MR. WREN: I was thinking of the person
18 who could not pay.

19 MR. LUDLOW: Now then, sir, it possibly
20 is not known to a great many of your Committee members
21 about an agreement between the Province and the Medical
22 Association whereby persons in receipt of public
23 assistance - that is relief, old age assistance,
24 and some receiving old age security by the means
25 test, disabled persons, and some other categories
26 receive this medical card from the Medical Association.

27 The Province pays a certain amount each
28 month, based on the number of persons. It is a
29 per capita way. I have forgotten - I don't want
30 to make a rash statement, but it is somewhat over



1 a dollar per month per person in receipt of these
2 allowances.

3 THE CHAIRMAN: And that payment or grant
4 is paid by?

5 MR. LUDLOW: Medical Association. The
6 recipient of this pension or assistance then selects
7 the doctor of their choice; their doctor then bills
8 the Medical Association for his services, and is
9 paid by the Medical Association for same.

10 MR. WREN: He is paid within the limits of
11 the Fund?

12 MR. LUDLOW: Yes. I believe that Fund
13 is pooled - this amount of money is pooled in
14 various districts for the doctors, so that they get
15 a percentage of that for each call or each service
16 they give.

17 MR. BRYDEN: Does that have anything to
18 do with drugs, or does it just cover medical service?

19 MR. LUDLOW: I have been away from and
20 not in touch with that branch for some years, looking
21 after just the homes for the aged, and I would not
22 like to make any statement with regard to that because
23 I may be incorrect. That can be received from the
24 Department.

25 THE CHAIRMAN: I wonder if you and Dr. Stuart
26 might not discuss with the Deputy Minister the
27 possibility of having us receive a statement from
28 the Department with respect to welfare operation as
29 such?

30 MR. LUDLOW: For medical and drugs?



1 THE CHAIRMAN: With emphasis directed to
2 the drug aspect.

3 MR. LUDLOW: Yes.

4 THE CHAIRMAN: Also as to what figures
5 might be available or where we might look for the
6 figures to ascertain drug costs.

7 MR. LUDLOW: I think he can give you information
8 on that.

9 THE CHAIRMAN: Any other questions of Dr.
10 Stuart, gentlemen?

11 MR. BOYER: Just one thing: residents in
12 the homes who are able to pay for their own medical
13 care and drugs, are those prescriptions still reviewed
14 by the house physician, home physician and the super-
15 intendant?

16 MR. LUDLOW: If they are in doubt.

17 MR. BOYER: What I was wondering about
18 the total cost of drugs in those homes: would there
19 be any record of what that cost would be?

20 MR. LUDLOW: No, not an official record
21 of that cost in that particular type of instance.
22 There certainly would be knowledge of it because
23 those things are bruited about.

24 MR. BOYER: There would be no way we could
25 find out?

26 MR. LUDLOW: There would be no record of it.

27 MR. WREN: Do you say the house physician
28 does review the prescription if the man is paying
29 his own bill?

30 MR. LUDLOW: On occasion if the person



1 - if it is creating a hardship to that person - some
2 of these people are able to pay their per diem cost
3 and have very little left over, and if they tell
4 the nurse they cannot afford it, this is too difficult,
5 then the house physician does come in on it.

6 MR. WREN: But if he were well able to
7 pay --

8 MR. LUDLOW: That is their own private bus-
9 iness.

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1 MR. FULLERTON: Are the blind organizations
2 operated through the Department of Welfare, and do they
3 take care of their own treatment.

4 DR. STUART: I cannot answer that. I don't
5 know whether Mr. Ludlow can or not. Are the drugs
6 and medical care costs of the blind taken care of
7 through our Department?

8 MR. LUDLOW: In the blind institutions are
9 the drugs taken care of?

10 DR. STUART: I thought he meant on a local
11 level.

12 MR. FULLERTON: Does the Department of Welfare
13 take care of the blind institutions as far as welfare is
14 concerned?

15 MR. LUDLOW: The blind institutions are
16 operated under The Charitable Institutions Act. That
17 is the homes, not any of the centres and things of that
18 kind that they have in connection with that, we will
19 say, here in Toronto or in Hamilton, where they have a
20 centre for the blind. They have a residence as they
21 call it, where a lot of the elderly blind persons live
22 in a home for the aged. Those expenses are cared for
23 and they get a grant or subsidy from the Department of
24 75%, of the net cost of operating that home, and the
25 drugs would be included if they expended drugs for
26 someone living in the residence, but not for those who
27 might visit the centre or whatever they call it, the
28 work rooms, no.

29 But there is, as I mentioned previously that
30



1 ceiling of 75% up to \$3.40 per day. Some of the blind
2 institutions cost less than others to operate.

3 Does that answer you, Mr. Fullerton?

4 MR. FULLERTON: Yes.

5 THE CHAIRMAN: Thank you gentlemen.

6 It being almost 12:30, this would be a good
7 time to adjourn for lunch. Is 2 o'clock in order,
8 gentlemen? We will proceed with the Department of
9 Reforms Institutions.

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11 --- Luncheon adjournment.
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1 THE CHAIRMAN: Gentlemen, it being 2 o'clock
2 we will resume. I am going to call on the Deputy
3 Minister of the Department of Reform Institutions,
4 Mr. J.A. Graham, to speak for his department.

5 --- Mr. J.A. Graham comes forward.

6 MR. GRAHAM: Mr. Chairman, gentlemen, first
7 of all I have no report to give you to study because
8 our department does not cover hospitals as such.
9 However, if you require a written report we will pre-
10 sent one to you. At the outset I wish to state that I
11 have with me Dr. Mellow who has been with the Civil
12 Service for 25 years and has been the medical officer
13 at The Ontario Reformatory at Guelph for 21 years. I
14 brought him along as there may be some questions re-
15 garding the medical side of our work that he could
16 assist me with.

17 In the first instance, the Minister of our
18 Department is responsible for the administration of 10
19 Acts or Statutes namely: The Reformatories Act, The
20 Ontario Reformatories Act, The Mercer Reformatory Act,
21 The Jails Act, The Female Patient and Prisoners Pro-
22 tection Act, The Female Refugees Act, The Parole Act,
23 The Penal and Reform Institutions Act, The Reformatories
24 Act and the Training Schools Act.

25 Then of course, we are under the jurisdiction
26 also of The Criminal Code, of course, and the Prisoners
27 and Reformatories act, that is, the Federal Prisoners
28 and Reformatories Act, Chapter 217.

29 In the first instance, our Department has
30 control of over 67 institutions. We have direct control



1 over 24 institutions, and the others are partially con-
2 trolled by us. I refer to the County and City Jails.
3 There are 35 County Jails and 2 City Jails, namely
4 the Metropolitan Jail, Toronto, and the Hamilton Jail.
5 With those County Jails or Municipal Jails as they are
6 sometimes called, we have indirect control. That is,
7 we inspect them and supervise their administration,
8 but we have nothing whatsoever to do with the purchase
9 of any materials, maintenance, or anything else to
10 operate that jail. Therefore, drugs as such are
11 purchased and paid for by the County Council.

12 Therefore, I think I will confine my remarks
13 chiefly to those institutions which are our direct
14 responsibility and those institutions are 24 in number;
15 namely - and I will read them off to you so that I
16 won't miss any of them.

17 We will start with the Ontario Training
18 School at Brampton. I might at the same time include
19 the population while I am reading them off.

20 The Ontario Training School, Brampton - and
21 I give you round figures here, the average daily count
22 for the fiscal year ending March 31st, 1960 was 181.

23 THE CHAIRMAN: That is population?

24 MR. GRAHAM: In the population.

25	Ontario Training School Brampton	181
26	Industrial Farm, Burtch	191
27	Ontario Training School, Burtch	30
28	Industrial Farm, Burwash	688
29	Industrial Farm, Fort William	88
30	Ontario Reformatory, Guelph	900



1 Ontario Women's Guidance Centre,
2 Brampton 5

3 Mercer Reformatory 119

4 Ontario Reformatory, Millbrook 193

5 Ontario Reformatory, Mimico 430

6 THE CHAIRMAN: Not too quickly. You lost me
7 at the Women's Guidance Centre, Brampton.

8 MR. GRAHAM: Yes. That is not quite a true
9 picture, because we only opened the institution last
10 September 1st, and they are a selected group, but we
11 have a higher population there now. After that -

12 THE CHAIRMAN: After the Women's Guidance
13 Centre.

14 MR. GRAHAM: Mercer Reformatory.

15 THE CHAIRMAN: How many?

16 MR. GRAHAM: 119.

17 Ontario Reformatory, Millbrook 193

18 Ontario Reformatory, Mimico 430

19 Industrial Farm, Monteith 130

20 Rideau Industrial Farms 123

21 Ontario Training School for Boys,
Bowmanville 213

22 Ontario Training School for Boys,
23 Cobourg 178

24 Ontario Training School for Girls,
Galt 179

25 Ontario Training School for Boys,
26 Guelph 39

27 That makes a total, the average population last fiscal
28 year of 3,687.

29 THE CHAIRMAN: That is for 24 directly
30 controlled institutions.



1 MR. BOYER: Where do the district jails come
2 in?

3 MR. GRAHAM: They come directly under us,
4 I am sorry.

5 There are 8 district jails. I nearly omitted
6 them. The 8 I read off are included in the 24. I
7 gave you 16 names. If you add them up with the 8
8 district jails you will get the total.

9 The district jails are located at:

10 Fort Francis	10.4
11 Haileybury	31.3
12 Kenora	50.8
13 Parry Sound	24.2
14 Port Arthur	75.9
15 Sault Ste. Marie	71.9
16 Sudbury	76.3
17 North Bay	39.1

18 THE CHAIRMAN: What does that total up to now?

19 MR. GRAHAM: You mean population, sir?

20 THE CHAIRMAN: Yes.

21 MR. GRAHAM: 3687 and 379, 4,066.

22 THE CHAIRMAN: That is what, average daily
23 population?

24 MR. GRAHAM: That is right, sir.

25 Our institutions submit requisitions for
26 their drug requirements for a three month to a six
27 month period depending on the type of drug required
28 and the population of the institution.

29 In cases of emergency such as delay in re-
30 ceiving supplies and subscriptions from the local



1 doctor, the institutions are permitted to make purchases
2 of these items. When brand name drugs are specified
3 by the doctor, these are purchased: However, if no
4 mention is made, then generic drugs are purchased.

5 I might say that the Ontario Reformatory at
6 Guelph is the only institution that does purchase its
7 own drugs, the reason for that being that we have at
8 the Ontario Reformatory at Guelph a section of the
9 institution known as the Neuro-Psychiatric Clinic,
10 where we place men who are disturbed but who are not
11 psychotic to the extend that they are certifiable for
12 mental hospital, and they are placed in the Neuro-
13 Psychiatric Clinic for observation and treatment.

14 Dr. Mellow is with me and he can explain
15 more about the psychiatric clinic because that is what
16 he has direct supervision over.

17 I should say that Guelph and Burwash and
18 Mimico have full time resident physicians. Guelph has
19 two, Burwash has 2 and Mimico has one. The other in-
20 stitutions have a part time physician. I think you can
21 readily see that the reason for that is because of the
22 population.

23
24
25 (Page 332 follows)
26
27
28
29
30



1 MR. GRAHAM: We also have full time
2 registered nurses at Guelph and Burwash and Mimico,
3 and also at the Mercer and all training schools have
4 full time registered nurses.

5
6 Our institution, I don't think, can be
7 compared with the Ontario Hospitals as there is only
8 a small percentage of inmates who would be classified
9 in hospital confinement categories. That is to say,
10 that if they are seriously ill, they are transferred
11 to a general hospital. We only treat minor illnesses
12 and the inmate through a convalescent period.

13 Now the drugs purchased for the fiscal
14 year ending March 31, 1959, the cost of the brand
15 named drugs was \$26,409.99 and the cost of generic
16 drugs for the fiscal year ending March 31, 1959
17 was \$9,173.99, making a total cost of drugs for the
18 year \$35,583.98. That works out to, if you divide it
19 out, around \$8.75 per inmate per year.

20 Now, sir, I have nothing more to report on
21 this unless there is some question to ask because
22 with the population of that kind you can see that
23 the expenditure is not too great.

24 THE CHAIRMAN: Mr. Graham, would Dr. Mellow
25 or Mr. Cunningham be in a position to talk about
26 the inventory factors and the type of drugs which
27 were used, the types of diseases or illness?

28 MR. GRAHAM: Yes, I think Dr. Mellow could
29 answer a question of that kind on the types of
30 diseases. He is well qualified to do that.



1 MR. WREN: Mr. Chairman, let me ask the
2 witness one question. This came to my attention
3 recently. What happens in cases of prisoners who
4 are severely injured, or acquire or become ill while
5 in prison and later require extended treatment and
6 some rather expensive drugs to rehabilitate them-
7 selves? Whose responsibility is that? Yours or
8 Welfare?

9 MR. GRAHAM: I think, Mr. Wren, that is
10 Welfare. Once they are discharged from our custody
11 a prisoner, if he injures himself while he is in our
12 custody, or if he becomes seriously ill, at the end
13 of his sentence he has the privilege of remaining
14 in custody until he is physically able to work. He signs
15 a waiver to that extent; that he is willing -- that
16 is in the Statutes -- that he is willing to remain
17 in custody until he is perfectly fit and ready to go
18 to work.

19 If he refuses to remain in our custody
20 and receive our treatment, then he is discharged
21 from custody.

22 MR. WREN: I wouldn't suppose that the
23 Compensation Board would come in on industrial
24 accidents?

25 MR. GRAHAM: No.

26 MR. WREN: I have in mind one case where,
27 I don't want to mention names and embarrass individuals,
28 where the man up our way was severely injured,
29 a power saw ripped his arm one end to the other
30



1 and I imagine he became incapacitated for life.
2 Apparently he has been in need for some rather
3 expensive drugs to do with relaxing muscles.

4 MR. GRAHAM: I know the case you are
5 referring to. I know it very well.

6 MR. WREN: Probably you do.

7 MR. GRAHAM: So we will stay away from
8 the names. I will tell you what we are doing with that
9 case right now.

10 That man injured himself, rightly or
11 wrongly but according to the report we have by his
12 own absolute carelessness. However, we kept that
13 man in custody, signed a waiver to remain in custody
14 because he was taking physiotherapy treatments twice
15 weekly. Then it came to the time when the doctor
16 said well I think he could be released but he will
17 have to have another operation, so we asked the man
18 if he wished to be discharged and he said he would.
19 We discharged him.

20 Now he is back in hospital again and just
21 about, I would say, within the last three weeks,
22 the doctor wrote us and asked us if we would be
23 responsible for the cost of the operation and
24 expenses involved and we told him we would so we
25 deal with each case on its own merits. That is what
26 we are doing in that case.

27 MR. BOYER: Mr. Chairman I would like to
28 ask a question about procedure in the case of an
29 inmate who has been under -- who has been taking
30



1 prescriptions say from a doctor, or who says he has
2 been and wants to continue it, now what happens?
3 Is he examined by the prison physician to see whether
4 that medication should be changed, or is there
5 reference made to his own doctor? Something of that
6 sort?

7 MR. GRAHAM: The doctor will examine him
8 and at the same time he will write to his own doctor
9 to see just what treatment he has been receiving.
10 That is exactly what we do.

11 THE CHAIRMAN: Thank you Mr. Graham. Before
12 you go, you have given us the total dollar figures.
13 How are these purchases made? It is obvious that
14 by brand names you would have to purchase from the
15 company manufacturing. But what is the procedure
16 and will Mr. Cunningham deal with this?

17 MR. GRAHAM: Mr. Cunningham, I think, is
18 prepared. I will let him answer that although I know
19 what it is. I think Mr. Cunningham will answer the
20 question.

21 THE CHAIRMAN: Don't let me interfere
22 with the order that you wish to proceed in.

23 MR. CUNNINGHAM: Gentlemen, it is my
24 pleasure to be here to give that information.
25 There are several drug companies who we deal with
26 for the generic drugs. There are others for brand
27 names.

28 Now, do you want me to call them off in
29 a hurry, or do you want me to take time?
30



1 THE CHAIRMAN: It might be helpful to the
2 Committee if you would care to file the list with
3 the Committee.
4

5 MR. CUNNINGHAM: All right, I will be glad
6 to do that, sir. I have them right here, if you
7 don't want me to mention them.

8 THE CHAIRMAN: It doesn't matter to me.

9 MR. CUNNINGHAM: I will give you a copy of
10 this list.

11 THE CHAIRMAN: Proceed.

12 MR. CUNNINGHAM: All right, sir.

13 THE CHAIRMAN: What is the procedure on
14 purchasing? What periods do you purchase for?

15 MR. CUNNINGHAM: Well we prefer three
16 months to a six-month period. We will take, for
17 instance, a district jail like North Bay or Haileybury
18 where they are small institutions it is a six-
19 month period.

20 Burwash, a bigger institution, whatever
21 period they figure works out right. Our reason is
22 we have got to consider the space in our dispensary.
23 In other words, if we are buying drugs say by the
24 year, we may get a better price but in the meantime
25 in your dispensary if you have any breakages, or
26 anything, your profit has gone down the drain, and
27 with that in mind we figure it is better to buy in
28 lesser quantities, three months or four months,
29 three months or six-month period.
30

THE CHAIRMAN: What is the sales tax factor



1 with respect to that?

2 MR. CUNNINGHAM: All our orders, of course,
3 have to be certified as sales tax not included.

4 THE CHAIRMAN: Exempt?

5 MR. CUNNINGHAM: Definitely. In fact, the
6 Treasury Department they won't pass invoices unless
7 that certificate is on the invoice.

8 THE CHAIRMAN: When you are making a
9 purchase, are you buying for all of the institutions?

10 MR. CUNNINGHAM: With the exception of
11 Guelph, As Mr. Graham explained to you that is a
12 large institution, have got two doctors there and
13 have got sufficient purchasing staff there, and as
14 far as that goes we still get a copy of their order
15 irrespective of what they do, so we still have
16 control over Guelph in some respects.

17 THE CHAIRMAN: Then what do you do with
18 respect to the category of purchases by generic
19 names?

20 MR. CUNNINGHAM: Well we send out tenders.
21 We generally allow them possibly a week, a week to
22 ten days depending on the size of the order going
23 through and we send out to about eight or nine
24 companies.

25 THE CHAIRMAN: Who are manufacturers?

26 MR. CUNNINGHAM: Manufacturers, yes, sir.

27 THE CHAIRMAN: Are those eight or nine
28 all manufacturers or would they be distributors?

29 MR. CUNNINGHAM: Eight to nine, not
30



1 eighty-nine.

2 THE CHAIRMAN: Eight or nine?

3 MR. CUNNINGHAM: That is right.

4 THE CHAIRMAN: Are they manufacturers or
5 distributors?

6 MR. CUNNINGHAM: Well I would say they are
7 manufacturers.

8 THE CHAIRMAN: What I am getting at is:
9 are the goods made in Canada?

10 MR. CUNNINGHAM: These ones, yes. As far
11 as the generic, definitely.

12 THE CHAIRMAN: What testing or quality
13 control do you apply?

14 MR. CUNNINGHAM: Actually, sir, we have no
15 testing but we feel that the companies that we are
16 dealing with are quite reputable firms. As far as
17 having anything tested, as I said, we never had any
18 complaints or anything. If we do, they are very,
19 very little.

20 THE CHAIRMAN: Do you know of any complaints?

21 MR. CUNNINGHAM: No. To be honest, no.

22 THE CHAIRMAN: Where would the complaint
23 come from if they did arrive?

24 MR. CUNNINGHAM: Should come from the
25 Medical Officer up in the institution.

26 THE CHAIRMAN: Tell us a little bit about
27 Guelph. It is obvious you must have a pharmacy there
28 or stock room?

29 MR. CUNNINGHAM: No pharmacist in any of
30



1 our departments.

2 THE CHAIRMAN: In Guelph, tell us what
3 you have there.

4 MR. CUNNINGHAM: Well I think Dr. Mellow
5 would be better qualified to explain Guelph.

6 THE CHAIRMAN: Would you be able to tell
7 us what would be the value of your inventory of drugs
8 at Guelph say at a peak period?

9 MR. CUNNINGHAM: I don't think it would be
10 too much because as a rule we try to keep our
11 inventories down.

12 THE CHAIRMAN: It would obviously be
13 something.

14 MR. CUNNINGHAM: Well I don't think I could
15 answer that one either. I don't know whether Dr.
16 Mellow could either.

17 THE CHAIRMAN: The day after the three to
18 six-months orders were delivered you would have a
19 stock on hand?

20 MR. CUNNINGHAM: Well generally what they
21 do, they keep a record and if their stock gets down
22 to I would say about half, then it is time to re-
23 order. I think they check along that way.

24 THE CHAIRMAN: You would have no information
25 then on that?

26 MR. CUNNINGHAM: No. As far as the
27 dispensary in our institution, with the exception
28 of Guelph, Burwash, the other ones are quite small
29 places. Just little bits, so they couldn't keep too
30



1 much anyway.

2 THE CHAIRMAN: I mentioned Guelph, but I
3 was thinking of the institutions including Burwash
4 and Mimico where there were resident doctors. Let's
5 now refer to the other 19 institutions where they
6 have no doctor. Now what kind of stock would you
7 maintain there?

8 MR. CUNNINGHAM: What they do there they
9 have, what you might call -- generally they have
10 someone that has been in the Army or in the Medical
11 Corps, somebody that is interested in drugs, of
12 course, under the supervision of the part time doctor,
13 or in other words he knows what they are ordering,
14 and so on.

15 THE CHAIRMAN: Would you have any infor-
16 mation as to what stock would be carried at Millbrook?

17 MR. CUNNINGHAM: No, sir.

18 THE CHAIRMAN: I wonder, Mr. Cunningham,
19 and Mr. Graham, if it would be possible for us to
20 get some information.

21 MR. CUNNINGHAM: I think we could.

22 THE CHAIRMAN: Just as if you were taking
23 inventory at any date to see what the value of this
24 stock would be.

25 MR. CUNNINGHAM: Yes, we could do that.
26 Any specific time? Up to the present time? What
27 they have got there tomorrow, or today?

28 THE CHAIRMAN: We don't want to put you
29 to a lot of trouble; whatever would be a logical
30



1 or convenient day.

2 MR. CUNNINGHAM: All right, make a specific
3 day. Now tell me, sir, you wouldn't want---

4 THE CHAIRMAN: Let's take a date, such as
5 the 30th of September.

6 MR. CUNNINGHAM: Very good, yes, that would
7 be all right.

8 THE CHAIRMAN: Would your records be
9 available for the 1st of July?

10 MR. CUNNINGHAM: Well we could make it
11 the 30th of September and then have a more up-to-date
12 picture. Would that be all right?

13 THE CHAIRMAN: Yes.

14 MR. CUNNINGHAM: Tell me, sir, with the
15 district jails, do you want them too?

16 THE CHAIRMAN: If they come under your ---

17 MR. CUNNINGHAM: They do, but I mean we
18 would have to write them but if you want them, we
19 certainly can get them also.

20 THE CHAIRMAN: Might be able to use the
21 O.P.P. radio-telephone.

22 MR. CUNNINGHAM: Get them on long distance
23 calls.

24
25
26
27
28
29 ---Page 343 follows.
30



1 THE CHAIRMAN: I think that would be of
2 interest. Coming back to your purchasing would you
3 have any idea how many different types of drugs
4 within the definition and spirit of the word "drugs"
5 that this Committee has before it, how many different
6 types or items you are concerned with?

7 MR. CUNNINGHAM: I have a list here of
8 the generic drugs. An individual list of them. I
9 could give you that.

10 THE CHAIRMAN: Would you do that?

11 MR. CUNNINGHAM: Yes, I would be glad to.
12 Do you want one of the others, one on the brands?

13 THE CHAIRMAN: Both. Before we put you
14 into an impossible task, would this list total
15 something like one hundred or two hundred or is it
16 two thousand?

17 MR. CUNNINGHAM: You mean the number of
18 names?

19 THE CHAIRMAN: Yes.

20 MR. CUNNINGHAM: I would say, and this is
21 guesswork, and I might be out a bit, but I would say
22 about three hundred. Cough mixture and everything
23 that goes along with it.

24 THE CHAIRMAN: You might speak to the secre-
25 tary, Mr. Gadsby, about this, and he might assist
26 you in what we describe as drugs.

27 MR. CUNNINGHAM: Yes.

28 THE CHAIRMAN: We exclude certain types of
29 things and ward supplies and so on.

30 MR. CUNNINGHAM: I will be glad to do that.



1 I will give you a list of the drugs, generic, and also
2 the brand names, plus the names of the companies we
3 have been dealing with.

4 THE CHAIRMAN: Yes.

5 MR. CUNNINGHAM: All right, sir, and then I
6 can get an inventory on September 30 for the institutions.
7 Very good, sir. Thank you.

8 MR. BRYDEN: Might I ask a couple of questions?

9 THE CHAIRMAN: Yes.

10 MR. BRYDEN: I understand from what has
11 been said by you and the Deputy Minister as well
12 if a doctor orders - at least if a local doctor in
13 the institution orders a drug by the brand name,
14 it is usually bought under that name?

15 MR. CUNNINGHAM: Yes.

16 MR. BRYDEN: With regard to the purchases
17 under generic names, you said there were eight or
18 nine firms that you asked to submit tenders?

19 MR. CUNNINGHAM: Yes.

20 MR. BRYDEN: On what basis do you select those
21 firms?

22 MR. CUNNINGHAM: Well, that is the only
23 names we have got on the list. If anybody else wants
24 to tender, we are glad to give them an opportunity
25 to quote, but we have got a list that we keep, what
26 you would call a mailing list, and if anybody comes
27 and says "we would like to quote", we say "all right,
28 we will give you an opportunity to quote".

29 MR. BRYDEN: I suppose that list you talk
30 of would include firms that manufacture a product



1 under the brand name, and this quote will be in respect
2 to their brand name?

3 MR. CUNNINGHAM: Yes.

4 THE CHAIRMAN: We have eleven on this Committee,
5 and sometimes they like to ask a question.

6 MR. FULLERTON: Is there much variance in
7 price on a specific drug in your tenders?

8 MR. CUNNINGHAM: Not a great deal.
9 Then again we get back to the large quantities. Like
10 Burwash, we have possibly 25,000, take as an example,
11 aspirin tablets. Another institution might only have
12 5,000. Naturally there might be a difference. You
13 pay a little more.

14 MR. FULLERTON: Let's say 50,000 of a specific
15 drug - 50,000 pills. Is there much difference between
16 the companies?

17 MR. CUNNINGHAM: Not a great deal, no.
18 Not a great deal, but just enough. When you are
19 buying in a big quantity, a few cents makes a difference.

20 MR. WREN: Have you ever had any experience
21 where all the tenders for a specific drug were the
22 same amount?

23 MR. CUNNINGHAM: No. Never have any trouble.
24 Nobody ever mentioned why they do this or don't do
25 the other thing. Seemed to be quite satisfied. They
26 know we operate, and that is it.

27 THE CHAIRMAN: Probably at that point we
28 are getting off into the Federal field of legislation,
29 which we are striving to avoid.

30 MR. TROTTER: I would like to ask do the drug



1 firms ever come to you and try to sell drugs?

2 MR. CUNNINGHAM: Not too many. In fact,
3 a very small percentage. The odd time when some of
4 them maybe are not getting any business, they want
5 to come up and find out why they are not. We tell
6 them their prices are not in line, and they go away
7 quite happy.

8 THE CHAIRMAN: Thank you, sir.

9 ---Dr. Mellow comes forward.

10 THE CHAIRMAN: Dr. Mellow, your initials are?

11 DR. MELLOW: G. A.

12 THE CHAIRMAN: What is your title?

13 DR. MELLOW: Doctor.

14 THE CHAIRMAN: Medical officer?

15 DR. MELLOW: At Guelph. Have you some
16 questions you would like to ask, or would you like
17 a description?

18 THE CHAIRMAN: We would like to hear from
19 you, Doctor, and you might follow this line among
20 others: the story of treatment of prisoners and
21 the nature of the facilities which you have available,
22 the extent to which drugs are used, the type of
23 ordering or prescribing, the use of formulary or a
24 list of approved drugs, if any, and some such similar
25 matters.

26 Also, with respect to the field of medicine,
27 I would like you to identify whether or not the prisoners -
28 the population in your institutions - are subject
29 to any particular classification or type of disease,
30 and are the types of drugs predominantly used of a



1 certain category.

2 DR. MELLOW: Well, Guelph has 900, roughly,
3 inmates. According to the classification they are
4 all inmates 20 years of age or under, except first
5 offenders. If they are first offenders, regardless
6 of their age they may go to Guelph.

7 The population varies between 900 and 950.

8 A few years ago a new hospital was built
9 at Guelph. It has two floors. The lower floor is
10 a general hospital, general sick bay or hospital.
11 The upper floor is for the care of, you might say,
12 psychiatric cases, inmates that are not in good
13 mental health. They are up there for treatment and
14 for investigation.

15 As far as the practice of medicine in an
16 institution like Guelph, I would say you run into
17 very much the same type of cases, the same type
18 of injuries and illnesses that a practising physician
19 on the outside would. There is a certain amount
20 of flu and colds and surgical emergencies such as
21 appendicitis, and you give a certain amount of corrective
22 surgery such as repair of hernia and removal of tonsils.

23 There is a certain amount of injuries
24 that the inmates receive in the shops, in the sport
25 field, and things like that.

26 As far as the drugs, the keeping up of our
27 drug stock, I think we have a rather large stock of
28 drugs. We have a drug room which is of course strictly
29 kept locked. I think it has a pretty full supply of
30 drugs, because we have a pretty large population.



1 The way we order drugs at Guelph is through
2 an order pad. When we notice a drug getting low,
3 we just write it down on this order pad. Any form
4 of drug or anything to do with medicine goes on that
5 pad, and unless we are in a hurry to get a certain
6 product, when that pad is full we turn it into the
7 purchasing officer, and then he puts out a tender,
8 and I presume buys where the price is best. Certain
9 drugs we want by their trade names, and they are
10 so ordered.

11 On the upper floor in the neuro-psychiatric
12 centre - that is mainly a place as I have mentioned
13 for observation of nervous disorders and treatment
14 and disposal, and you will get a certain amount of
15 psychotic individuals and they are certified and
16 sent to various Ontario Hospitals.

17 I think this centre has helped a great deal
18 in the smooth running of the institution because of
19 the individuals with nervous disorders, quite often
20 troublemakers, because of their nervous disorders
21 they are removed and segregated. I think it has
22 been a very good thing.

23 At the moment I cannot think of anything
24 much else to say. Have you any questions?

25 THE CHAIRMAN: Can we describe the 2nd floor -
26 how did you describe it?

27 DR. MELLOW: The name they gave it was the
28 Neuro-psychiatric unit.

29 THE CHAIRMAN: Neuro-psychiatric unit?

30 DR. MELLOW: A number of years ago the Depart-



1 ment built this new hospital. It consisted of two
2 floors. About 25 beds without crowding on each floor.
3 The lower floor is for general illnesses of the inmates,
4 and the upper floor is where we treat the neuro-
5 psychiatric patients. It is a modern hospital. We
6 have x-ray equipment. We have a radiologist that
7 helps us with our x-ray films and comes one afternoon
8 a week.

9 THE CHAIRMAN: How many beds?

10 DR. MELLOW: It will hold 25. 25 beds,
11 but if you want to use the sun parlor, it may be, without
12 too much crowding, you can get in five or six more
13 quite readily.

14 THE CHAIRMAN: Is this unit treated as a
15 research centre at all?

16 DR. MELLOW: As a research centre?

17 THE CHAIRMAN: As a research centre.

18 DR. MELLOW: No, not really. They have
19 talked a lot about research, but actually --

20 THE CHAIRMAN: Do any of the drug companies
21 use it as a clinical testing ground?

22 DR. MELLOW: No.

23 THE CHAIRMAN: Has that ever been considered?

24 DR. MELLOW: I have never heard it discussed.

25 THE CHAIRMAN: When you did not have that
26 unit at Guelph, what was done heretofore?

27 DR. MELLOW: Well, some of the inmates that
28 were not psychotic would just probably remain, some
29 of them, in circulation, and some of them we put
30 in the regular hospitals. Of course, as before, the



1 psychotic ones would be certified.

2 THE CHAIRMAN: Does the existence of that
3 unit lead to an unusual waiting or an additional use
4 of the drugs which are used in the branch of psychiatry?

5 DR. MELLOW: Does it do which?

6 THE CHAIRMAN: Does it lead to a greater use
7 of those drugs which are commonly attributed to or
8 used in the field of psychiatry?

9 DR. MELLOW: Well, we use a few more drugs
10 up there than we would otherwise. The consultant
11 psychiatrist who comes sometimes prescribes one of
12 the newer drugs on the market for treating of psychotic
13 patients such as the new drugs out used for depressions
14 and tranquillizers. I think those drugs are used a
15 little more than if we did not have the unit.

16 MR. WREN: Mr. Chairman, Dr. Mellow says
17 in Guelph they do not use any new drugs or any drugs
18 for testing purposes on prisoners. Are there any
19 prisoners in Ontario that you know of where new products
20 of any companies are used on prisoners for testing?

21 DR. MELLOW: We might use new drugs, but it
22 would only be after they had been put on the market
23 by the companies and considered safe and proper to
24 use. Never would we just try out a new drug that had
25 never been used.

26 MR. WREN: In other words, they would be
27 drugs that were purchased in the normal way?

28 DR. MELLOW: Yes.

29 MR. WREN: These companies never offer you
30 certain drugs free, shall we say, to try them out?



1 DR.MELLOW: No.

2 THE CHAIRMAN: There are two doctors at
3 Guelph, two at Burwash and one at Mimico, and the
4 rest are under local part-time men?

5 DR. MELLOW: Part-time men. I should
6 mention possibly now we have five trained nurses
7 at Guelph.

8 THE CHAIRMAN: Five?

9 DR.MELLOW: Five.

10 THE CHAIRMAN: Well now, let's take an
11 institution, Doctor, such as the Mercer or Millbrook,
12 Cobourg, Galt for girls, or any of those where there
13 are no doctors, the local doctor would come in and
14 he would then assess the patient?

15 DR.MELLOW: Yes.

16 THE CHAIRMAN: And would write out a prescrip-
17 tion?

18 DR. MELLOW: I presume so. That would be
19 a physician hired on a part-time basis by the Department.

20 THE CHAIRMAN: Well then, what would be
21 the procedure with respect to filling that prescription
22 in those other institutions?

23 DR. MELLOW: Well, I have never worked in
24 those institutions you mention, but I would presume
25 they would have the drugs that the doctor prescribed,
26 or else possibly - and I am only assuming - they would
27 send out and get them.

28 THE CHAIRMAN: Mr. Graham, could we get some
29 information at a later date?

30 MR. GRAHAM: I think I can answer that question



1 now.

2 THE CHAIRMAN: Yes.

3 MR. GRAHAM: In the institutions that you
4 have mentioned, the doctor visits the institution
5 three times a week. Let's take Rideau Industrial
6 Farm. Dr. Beamish visits the farm three times a
7 week, and more often if there is an emergency case.

19 Page 358 follows.



1 He only keeps on hand there the everyday drugs for
2 common everyday ailments.

3 If there is an emergency, he will write a
4 prescription and send it right in to the bursar of the
5 institution, and if it is needed within 15 minutes or
6 half an hour, they send a car for it right away. But
7 we don't keep a large quantity of any tranquillizer
8 drugs or anything like that on hand, because we have
9 to keep those under very strict lock and key and under
10 a very strict accounting.

11 THE CHAIRMAN: Apart from the average run-of-
12 the-mill type of thing which you have in stock at the
13 Rideau, if a prescription went beyond that, as you say
14 in an emergency, you would send a car for it.

15 MR. GRAHAM: That is right.

16 THE CHAIRMAN: Otherwise, you would let the
17 local druggist fill it in the normal course.

18 MR. GRAHAM: That is if it is an emergency,
19 and if it is not an emergency, it is sent to Mr.
20 Cunningham to purchase in the ordinary course.

21 THE CHAIRMAN: Would he have to wait.

22 MR. GRAHAM: If it is not an emergency, he
23 can wait for it. But if it is something that is
24 needed right away, and the man's health is being im-
25 paired as a result of not having it, he will get it
26 right away. We cannot afford to take chances on
27 waiting and fooling around with an inmate's life when
28 an inmate's life is at stake. If it is a case like
29 that, he might even take a local doctor, the part time
30 physician might say this man should go to hospital.



1 THE CHAIRMAN: Would that be the local
2 hospital?

3 MR. GRAHAM: That is right. At the Rideau
4 they would go to Smiths Falls.

5 THE CHAIRMAN: I don't want to prolong this
6 unduly, but could you think what kind of a medical
7 problem where there was no emergency there might be?
8 Could you give us an example where you would wait
9 until you sent to the Department in Toronto for a
10 prescription?

11 DR. MELLOW: Yes, I could give you an
12 example. For example, the other day we had a young
13 lad in our hospital with acute Eczema, not too acute.
14 He has had it for a long time and it was not clearing
15 up very well. We sent him up to the Dermatologist and
16 he ordered certain drugs. That would be a case in
17 which there was no emergency.

18 It just so happened that I had drugs that
19 were not exactly of the same name that he used, but I
20 could easily substitute the same drugs of another
21 company and wait until our order came in. There would
22 be no emergency whatsoever.

23 MR. WREN: If you had no substitute, what
24 would you do?

25 DR. MELLOW: In that case I would certainly
26 send downtown to the drugstore. I would not delay the
27 treatment.

28 THE CHAIRMAN: How long would it take for
29 a prescription to be filled if it came from the Rideau
30 down to the Department here?



1
2 MR. GRAHAM: That would take a week to ten
3 days.

4 MR. CUNNINGHAM: I would like to correct that.
5 If it is an emergency and they have not got it, they
6 are allowed to go downtown and get a small quantity
7 to keep them going until they can get it in.

8 In other words you cannot wait until they
9 send down to Toronto for it. They have to have it
10 right away, but where they have to have a small
11 quantity to keep them going, they can do that until
12 they get the order through.

13 THE CHAIRMAN: Alright. Gentlemen, are there
14 any other questions?

15 What measure do you use doctor, of assessing
16 the incidence of disease or accidents?

17 DR. MELLOW: I keep a yearly report.

18 THE CHAIRMAN: Is there any greater incidence
19 of disease among people who are in a reformatory or
20 institution than the rest of the population?

21 DR. MELLOW: I do not think there is any
22 difference in physical illnesses. I think possibly
23 on the whole a good many of them are more uneasy and
24 tense.

25 I think there would be no difference in
26 physical illness, but I think on the whole probably
27 the percentage of tense, nervous, slightly neurotic
28 people would be higher in an institution. They are
29 away from their home, and they have lost their freedom,
30 and that is only natural.



1 MR. SUTTON: I was wondering whether you
2 could tell us what other reform institutions have their
3 own hospitals.

4 DR. MELLOW: I know Burwash has a good
5 hospital.

6 MR. SUTTON: In your case there are 50 rooms
7 for a population of 900. Is your hospital pretty well
8 filled?

9 DR. MELLOW: No it is not. We are not at
10 all hard up for beds, we do very well with one exception.

11 Not every winter, but quite often we will get
12 an epidemic of flu. I have seen half the institution
13 down with flu and we have to put them to bed in a
14 dormitory and give them the regular treatment for colds
15 and flu in the dormitory. We take over the whole
16 dormitory and move the well people out. That happens
17 in an emergency. It may last a week or ten days and
18 then it is over.

19 MR. BOYER: Your hospital would not be used
20 for the staff, I suppose?

21 DR. MELLOW: No it is not. It used to be
22 in Burwash, because it is isolated. Years ago when I
23 have been up there I have seen officers treated up there.
24 But certainly in Guelph that never would be done unless
25 there was an emergency. He would go to the city hospital.

26 THE CHAIRMAN: Thank you, Dr. Mellow for
27 coming, and thank you Mr. Graham and Mr. Cunningham.

28
29 It is 3 o'clock and we are forced to retire
30



1 at this moment.

2 In any event, we will resume at 10 o'clock
3 in the morning and hope we will be through by noon.

4
5 --- Adjournment.

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